THE DECENTRALISATION OF PRIMARY HEALTH CARE IN THE METROPOLITAN REGION OF CAPE TOWN

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KEY WORDS

1. Primary health care
2. Metropolitan Area
3. Local authority
4. Decentralisation
5. Collective needs
6. Majority voting
7. Costs
8. Decision- making
9. Electorate
10. Optimum

ABSTRACT

In the interest of holistic integrated management, all functions and resources of primary health care should be transferred to the local authority through the process of decentralisation. Thereby placing all such services under a single authority. The reallocation of resources to local authority alternatives can reduce the cost of providing primary health care services. Such reduction does not necessarily imply budgetary savings; rather, it may imply increasing the number of people who are served or improving the quality of services for a given level of expenditure. The motive for decentralisation, if any, emerges from the majoritarian nature of the political process, efficiency and equity considerations.

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DECLARATION

I declare that *The decentralisation of primary health care in the metropolitan region of Cape Town* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Shaheeda Sechel **Date:** November 2002

Signed: ....

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SECTION 1

INTRODUCTION

The primary focus of this paper is to establish and argue the case for a decentralised[1] approach to the provision of an important public good – a case, which can be made in terms of both equity and efficiency considerations. This paper examines the validity of these views, in light of not only theoretical considerations but also in the specific context in which primary health care functions in the Metropolitan Area of Cape Town which is discussed in detail in section 4 of this paper.

Transferring authority as well as human and financial resources to the local authority entails both efficiency and equity factors. A reallocation of financial and other primary health care resources to local authorities permits greater *allocative efficiency* (in terms of generating the right mix) through adapting programmes to local needs and preferences. *Operational efficiency* entails the least cost approach to provide a given level of care. The Local Authority is able to deliver primary health care services at a lower cost than the national government. *Dynamic efficiency* relates to given increases in the quality and/or productivity of the factors of production. The *equity* requirement postulates that all members of society must have access to resources, which gives them the opportunity to generate a level of well-being above a certain minimum level established by society. In pursuing *equity*, existing differences between individuals are taken into account, and measures are adopted to address these differences. *Equity* embodies the principle of justice, and its interpretation is influenced by the dominant ideology within a particular society (McIntyre, 1998). The objective is to allocate

[1] According to the World Development Report (1999/2000, p108) decentralisation essentially entails the transfer of political, administrative and fiscal powers to lowest functional level capable of effectuating such a power. Rondinelli, 1981, provides a definition of decentralisation, he distinguished between three major forms of functional decentralisation, ranging from deconcentration, to delegation and devolution. Each form of decentralisation has different implications for institutional arrangements, the degree of transfer of authority and power, local citizen participation and efficiency.

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fairly and efficiently the primary health care resources and thereby achieving a more equitable distribution.

To accord priority improvements in primary health care delivery for those with the greatest capacity to benefit, it is important to find a mechanism in order to target resources to them. The Optimal Majority Voting Rule "OMVR" as propounded by Buchannan and Tullock is used to identify such individuals/groups and to target and mobilise resources and support for them. The argument for decentralisation of primary health care as an outcome of a majority voting process, is based on the expectation that in bringing the centre of strategic decision-making and management closer to the place where the service is provided and allowing public participation in this decision-making process, government would more efficiently and equitably meet health needs. This paper shows how decentralisation serves the cause of efficiency and equity through adapting programmes to local needs, preferences and circumstances.

The Optimal Majority Rule is subject to Arrow's famous Possibility Theorem. According to Arrow's analysis, voting does not guarantee a rational social choice. Arrow's possibility theorem (Arrow, 1951) demonstrates that aggregating individual preferences into a social choice will be highly problematic under all methods of making social choices. More than just showing that democratic decisions can lead to logically contradictory social decisions it established that in principle there is no social choice rule that possess the properties that will satisfy all of his requirements. It was stated by him as follows:

> "If we exclude the possibility of interpersonal comparisons of utility, then the only methods of passing from individual tastes to social preferences which will be defined for a wide range of sets of individual orderings are either imposed or dictatorial."

Arrow's possibility theorem is a logical conclusion and not an empirical statement.

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Methodology

Within the context of current patterns of service behaviour, using local public choice as the basic framework incorporating insights from the voting paradox and federalism, this paper presents an argument for the decentralisation of primary health care in favour of the local authority as service provider. Conclusions about decentralised provision of primary health care are based on a descriptive and comparative analysis of primary health care services as provided in the community health care centres, maternity outpatient units, school health services as well as fixed, satellite and mobile clinics in the public health sector in the metropolitan area of the Western Cape. Hospitals are excluded from this analysis. Assessments for service provision, demographic and health system features are based on the period January 1994 to December 2000. The geographic analysis focuses on the distribution of public sector resources within the metropolitan regions, relative to the population dependent on public sector services. Data are also provided relative to the total population in the metropolitan area of Cape Town.

The paper is organised as follows. **Section II** presents the standard notion of primary health care as a public good. **Section III** distinguish between Allocative Efficiency 1: Political Economy Considerations; Allocative Efficiency 2: Budgetary Allocation; Operational Efficiency: Budget Administration and Management; and Dynamic Efficiency. **Section IV** briefly describes the environment in which the local authority provides primary health care services. **Section V** concludes.

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SECTION II

CASE FOR DECENTRALISATION: PUBLIC GOOD CONSIDERATION

The nature of the good is of crucial importance to the efficiency of the method by which it is supplied. Some services can be provided less expensively on a larger scale, or their benefits may spill over across jurisdictions. Providing these services nationally, creates economies of scale and captures externalities, but at the cost of imposing a common policy on populations with varied preferences and priorities (WDR, 1999/2000). This section concentrates upon the question of efficiency and equity in the provision of a mixed good. Primary health care possesses certain characteristics that make decentralisation desirable.

Arrow (1963) pointed out most of the problems confronted by the primary health care sector that can generate non-optimal resource allocation. Essential to the analysis is the presumption of uncertainty that attaches health care. Several factors of health make it more complex and potentially more difficult than other sectors. Primary health care provides a situation in which the future time pattern of benefits and costs is not known with certainty, which makes it difficult to assign probabilities to future outcomes. (There are uncertain outcomes for which no probabilities of occurrence of the outcomes are available. There are situations in which the outcomes themselves may be unknown). This is compounded by the assymmetry in basic information accessible to individuals and government about the other.

Primary health care is not easy to specify or measure, as one cannot precisely describe the services one wants or the agent providing it. It differs in the nature of the risks they confront individuals with, the significance of imperfect and asymmetries of information and the importance that adverse selection and moral hazard plays.

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- *Lack of information*

Given the complexities in the way the human body functions as well as the technically complicated methods of care, consumers of primary health care, and to a lesser extent providers of primary health care, do not really understand how to gauge output in terms of either quantity or quality (Hilsenrath and Joseph, 1991). This is made worse by the fact that many illnesses do not repeat themselves, so that the cost of gaining the information is very high. Consumers often rely on the provider to determine the appropriate level of care, as the information possessed by the provider (as to the consequences for the client acquiring the service) is greater than that of the client. Direct measures of the quality of care are often unavailable and consumer use proxies such as technology and educational credentials are used as the principal determinant to judge quality.

- *Health related financial risk*

Moral hazard includes for e.g. the tendency to over-consume when the cost to the consumer is reduced (Pauly, 1968 in Hilsenrath and Joseph, 1991) and a lack of preventive concern when relative costless care is taken for granted. Those who know that they have a higher probability of needing expensive health care will try to insure themselves, whilst the healthy will tend not to.

- *Adverse selection*:

Insurers will try to enrol healthy individuals and avoid the unhealthy ones.

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To appreciate the nature of uncertainty surrounding the matter, it is necessary to note the difference between pure public and pure private goods and services. **Pure public** goods and services are characterised by the twin properties of **non-excludability** (it is very difficult to exclude someone from consuming the good) and **non-rivalry/non-subtractability** (consumption by one does not reduce availability to others). The fact that one person's consumption does not reduce the quantity available to other consumers implies that the marginal cost, i.e. the cost of admitting an extra user is zero. Excluding anyone from consuming a non-rival good is therefore not desirable from an allocative efficiency point of view. Public goods are used concurrently by many; and represent a particular type of beneficial externality. For example, it is difficult to exclude individuals from realising the

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benefits of vaccination programmes, clean water or better sanitation. There are also externalities in consumption where individuals benefit from knowing that others are well. **Private** goods and services are used or consumed exclusively and are subtractable. It is therefore efficient (although sometimes unfair) to exclude consumers who are not willing or unable to pay.

Due to non-rivalry, consumers of a public good have a low incentive to reveal their preferences and face the "free-rider" problem. Consumers of a private good have an incentive to find out and reveal their preferences for goods they think the benefits are greater than the costs. For efficient production under competitive conditions consumers need to reveal their demand for goods and services. If preferences are fully revealed the top-level condition for allocative efficiency - simultaneous achievement of equilibrium by consumers and producers - is met. For private, i.e. market-supplied goods, competition among producers, the profit motive among managers, and the desire to earn high incomes among workers encourage efficiency and work effort. For public goods, which are supplied through the government budget, bureaucratic forms of control induce efficiency (Ahmad, Hewitt, and Ruggiero in Ter-Minassian, 1997). Efficiency in the allocation of resources is best served by assigning responsibility for each type of public expenditure to the level of government that most closely represents the beneficiaries of the outlays (Ter-Minassian, 1997:4).

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A comparison of key characteristics of public and private goods:

Property rights	Non-excludable	Excludable
Consumption	Non-rival	Rival
Aggregate demand curve	Vertical addition of individual demand curves	Horizontal addition of individual demand curves
Partial equilibrium condition for optimal provision	The sum of marginal utilities = Marginal cost ($\Sigma MU = MC$)	Marginal utility of each consumer equals marginal cost ($MU = MC$ with i the individual consumer)
Efficient pricing rule	The sum of individual prices equals marginal cost ($\Sigma P = MC$)	Price equals marginal cost ($P = MC$)

Source: Reproduced from Black p.22

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In between public and private goods, one finds primary health care. Health is a state of complete well-being, (Meredith, 1995:34). Primary health care in essence covers curing illness, health education and disease prevention, initial assessment and treatment of acute and chronic health problems, rehabilitation and overall management of an individual's or family's health care services. Article VI of the Alma-Ata Declaration: World Health Organisation (1978), defines primary health care as:

> "Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation… It is the first level of contact of individuals, the family and community with the national health system, bringing care as close as possible to where people live and work and constitutes the first element of a continuing health care process."

Primary health care possesses private consumption benefit elements, which the individual consumer enjoys and at the same time public consumption benefits or externalities that other members of the community enjoy (Brown and Jackson, 1982:79). Primary health care is a mixed good characterised by rivalness in consumption and non-excludability. Rivalry in the form of competition for primary health care is fierce, and the marginal cost of primary health care usage increases as consumption increases. Benefits or costs go beyond the direct consumer, for e.g. prevention and treatment of communicable diseases, reduces the probability that others will become infected.

Graphic presentation of a mixed good

In figure 1(a) the demand curves D^1_{p} and D^2_{p} of individuals 1 and 2 for the private good X are shown. The total demand curve D^{1+2}_{p} is derived from *horizontal sum of* the individual demand curves. This includes a non-excludable element or externality in the sense that individual 1 benefits from individual 2's consumption and vice versa. In figure 1(b) individual 1's and individual 2's marginal

valuations of this public good element are shown by D^1_E and D^2_E. The total marginal valuation is the *vertical sum* of the two individual marginal valuation curves and is shown as D^{1+2}_E.

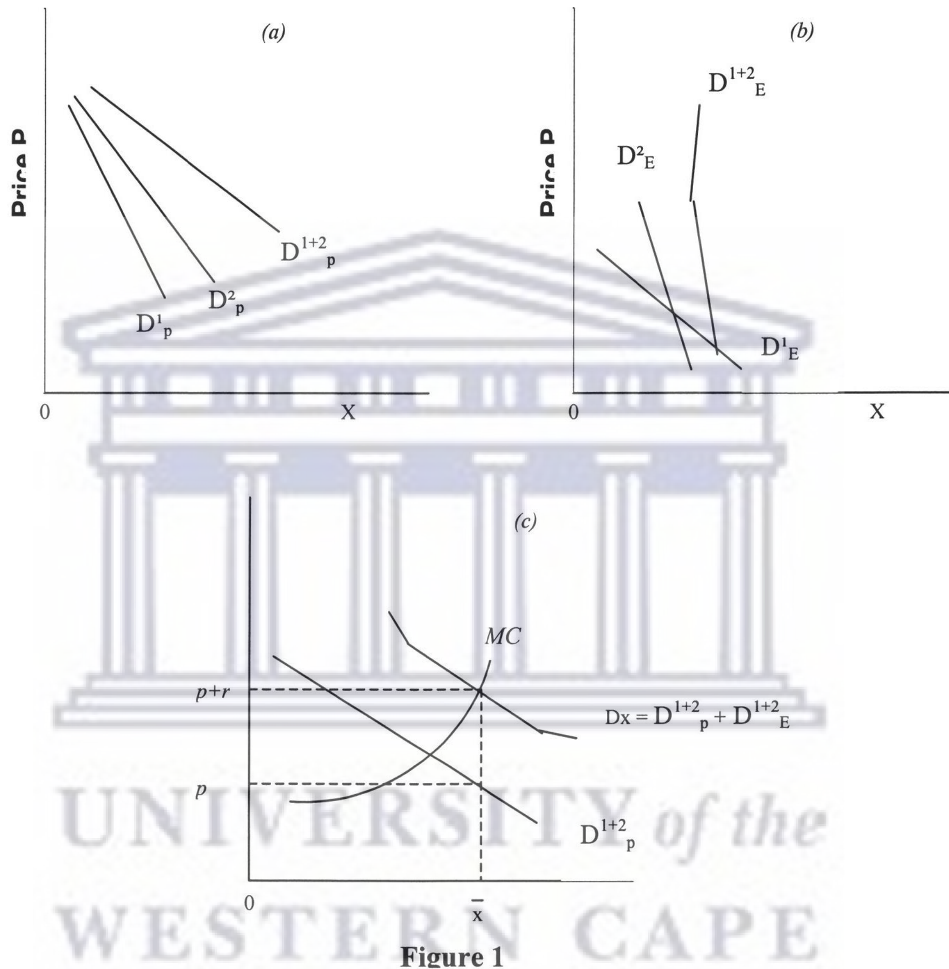

Figure 1

The overall demand curve is derived in figure 1 by vertically adding $D^{1+2}_p + D^{1+2}_E$. Given the marginal cost curve MC, the optimal output is *X*. The overall price *p* + *r* is made up of a market price element p and the social valuation of the externality *r*.

Reproduced from Brown and Jackson, p79

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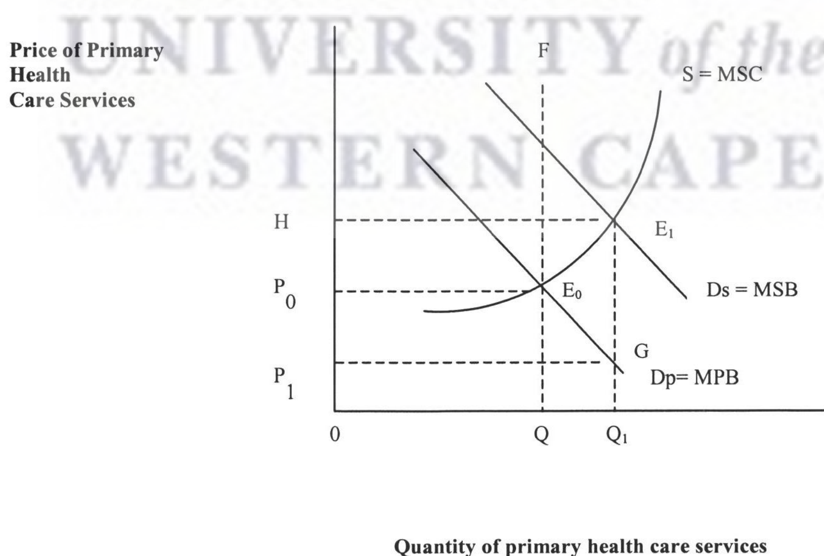
Sound economic reasons justify public provision of primary health care. The characteristics of primary health care suggest that the productivity gains to society are higher than the private rewards to individuals. Society thus expects the provider of primary health care to value the welfare of the individual and optimality of society. Primary health care can therefore be considered a merit good to be provided via the government budget.

Primary health care is a constitutionally mandated basic service. This right is entrenched and prioritise in the National Constitution's[2] Bill of Rights. This gives citizens a legal entitlement to basic primary health care services, which should be supported by organisational structures that deliver such services. There is thus a need for effective provision for citizen voice and their active involvement in structuring service provision and ensuring that these entitlements are actually realised.

Figure 2



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[2] The Constitution of the Republic of South Africa, Act 108 of 1996

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Figure 2 illustrates the above discussion. D_p and D_s represent the private and social marginal benefit curves respectively. S is the marginal social cost curve. Primary health care plays a special role in extending life. Improvements in the health status will be great for every extra rand spent on primary health care as primary health care is important for the protection and promotion of citizens well being. It goes hand in hand with lower morbidity and mortality rates and higher levels of production, thus relieving the pressures on the government, and hence on taxpayers, to provide additional social welfare. Thereby effectively reducing the welfare caseload.

The marginal social benefits from additional health exceed the marginal private benefits. This is shown in figure 2 – by the social demand (or MSB) curve, which lies to the right and above the private demand curve D_p. The gap between D_p and D_s is the result of the external benefits from primary health care. Point E_0, at which point there is no intervention, where the individual is in equilibrium, is not a social optimum. At point F, the price inclusive of the subsidy is high enough to induce a positive supply response. At the new equilibrium point E_1, where the marginal social benefit equals marginal social cost, the price paid by the consumers will be Q_1G (=OP_1), the unit subsidy will be GE_1 (=P_1H), and the supplier will receive Q_1E_1 (=OH). The provision of primary health care should be pursued to the point where the marginal benefits, when aggregated over individuals, equals marginal cost. For the subsidy to produce the optimal result, it must equal the marginal external benefit at the optimal output level Q1. Clearly, the final equilibrium represents a more efficient outcome with more primary health care services being provided at a lower unit demand price.

Primary health care embodies elements of redistribution (WDR, 1999/2000). Policies aimed at redistributing primary health care form the rich to the poor can be justified on Pareto grounds. The rich often will have a better life when there is better health care. In addition, the rich may find ill health disturbing in less tangible ways. The rich may also suffer from ill health because of the links to crime, disease, social unrest and poor national economic performance through an

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inefficient (because of unhealthy) labour force. The ability of the Metropolitan Area of Cape Town to redistribute effectively depends on the revenue base and the inter-jurisdictional mobility of the rich, poor and businesses.

Access to basic primary health care services contributes to the productive capacity of individuals. This has been a factor also identified by Arrow, 1963. Arrow pointed out that freedom of entry and access is not assured in health care markets. The majority of citizens have limited access to private clinics and hospitals, because of imperfect capital markets and information, travelling time, distance, etc. Inconvenience plays a significant role in allocating health services (Grumet, 1989 in Hilsenrath and Joseph). Consumers are relatively sensitive to travel time and high transportation cost with respect to demand for health services and are disinclined to use health services that are located far away. Direct subsidies in the form of strategically located primary health care institutions can effectively target low income and underserved populations. Primary care institutions deliver the most basic health care services. These institutions provide the first contact for health services and referral for secondary and tertiary level of care. It may be possible to substitute lesser trained for better-trained human resources with little or no effect on the quality of health services. Thus, ensuring closer contact with individuals is an excellent way of redistributing income. In this sense the local authority may be more efficient than the national government in ensuring primary health care redistribution.

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SECTION 111

CASE FOR DECENTRALISATION: EFFICIENCY CONSIDERATIONS

The following discussion addresses the efficiency implications of a decentralised primary health care system. It distinguishes between allocative efficiency, operational efficiency and dynamic efficiency.

A. Allocative efficiency 1: political economy considerations

The analysis that follows uses the "Optimal Majority Voting Rule" as propounded by Buchanan and Tullock as the decision-making mechanism by which local citizens can reveal their preferences for the decentralisation of primary health care. This approach through a cost minimising exercise, treats the local authority as service provider of Primary Health Care as an outcome of a majority-based decision on the part of self-interested voters.

Through the optimal voting process, individuals articulate their demand for primary health care and give elected local representatives a mandate on primary health care that should be translated into policies and programmes that benefit and reflect to a substantial extent the interests of the voters. As each individual votes in his own self-interest, the voting equilibrium corresponds with the median voter's most preferred outcome. The motive for decentralisation emerges from the majoritarian nature of the political process (Buchanan and Tullock, 1962:33-34).

The total cost involve in the politically institutionalised decision-making system is comprehensively defined so that, in addition to the costs of administering the system, the costs of participating in the decision-making process are considered along with the efficiency and distributional costs of the outcome (Brown, 1982:82). Buchanan and Tullock, p45 distinguish between two categories of costs: **1) decision-making costs** which are the costs that the individual expects to

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incur as a result of his own participation in an organised activity. It is the costs of acquiring and disseminating information, bargaining, administering, providing and managing. This refers to the input cost of primary health care; and **2) external costs** which are the costs of each individual's anticipated loss due to the prospect that collective decisions might harm him. It is the cost incurred by primary health care users due to poor performance or inadequate primary health care services. It is external to those users of primary health care whose preferences prevail. The social objective is to minimise total cost, which is the sum total of the decision cost and external cost.

Magnitudes of external costs (E) and decision costs (D) determine the number of members of a society that should participate in the decision-making process in order to arrive at a minimal-cost situation for primary health care. Extending the Buchanan and Tullock argument, it also determines the optimal level of service. At the minimum of (E+D) the fall in the marginal external costs will equal the rise in the marginal decision-making cost. In the given example this coincide with the percentage given by N_1. The optimal majority need thus not be an ordinary majority (i.e. 50% +1 vote). N_0/N_{max} is the proportion of the group that is required for a majority. This does not correspond to the efficient decision rule N_1/N_{max}. The optimal majority voting rule (i.e. that which minimises costs) would require that N_1 per cent of the group agreed before any decision is accepted. In terms of Buchanan and Tullock the minimum point on the total cost curve (E + D), point N_1 in figure 3 is the optimal voting percentage; and in terms of our extension, it is also an approximation of the optimal size of service. This relationship is graphically represented in figure 3.

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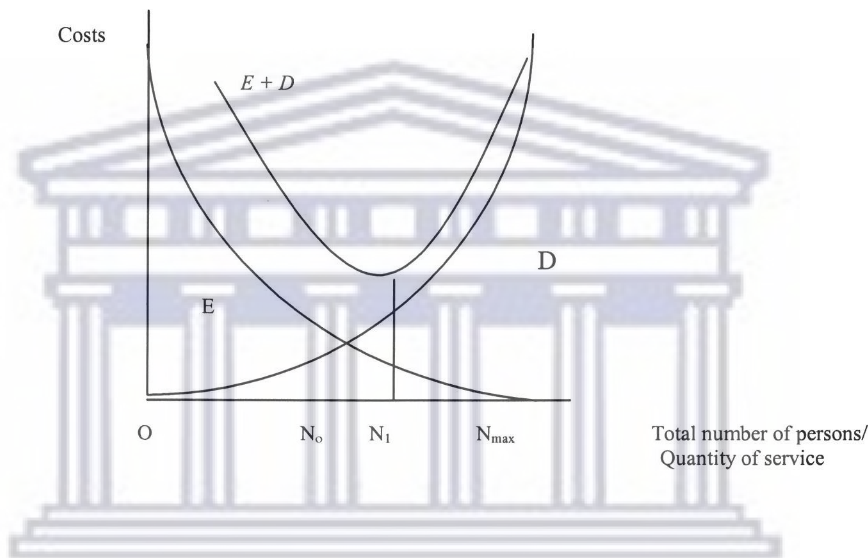
Figure 3

Decision-making cost, external cost, and total cost, depending on the size of the support base



The decision-making costs curve, represented by the D curve rises from left to right as the number of individuals required for a collective decision increases. Decision costs vary positively and external costs negatively with the percentage of voters. The external cost curve (the E curve) slopes downwards to the right – indicating a decreasing cost function

Source: Reproduced from Black, P66

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Buchanan and Tullock, 1962 argued that the size of the group is negatively related to solving collective-action problems in general. As the size of the required support base increases, external costs fall and become zero when unanimity (100 percent support) is reached. As unanimity is approached, the greater the opportunity to introduce own values into the decision-making process, and the smaller the danger that minorities can be harmed. Since any one individual could prevent the approval of a decision, no one would be made worse of. When one person makes decisions in respect of primary health care external cost will be extremely high. As such decisions will potentially ignore and undermine the interests of all other voters.

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The smaller the community of voters the easier it will be to reach a majority decision and the lower will be the decision-making costs. The higher the external cost (curve), ceteris paribus, the greater N_1 becomes; and the higher the decision-making cost and ceteris paribus, the lower N_1 will be (Black, 2000:66). The decision-making costs increase as unanimity is reached. As the size of the group increases it becomes increasingly expensive to induce individuals to reveal their preferences accurately and there is greater scope for an individual to become a "free-rider". Extra decision-making resources are, therefore, required to ensure that individuals reveal their preferences accurately. It becomes gradually more difficult, costly and time-consuming to make a decision that no decisions get made. The extent of allocative inefficiencies is reduced as the number of persons required for agreement approaches 100 per cent. A decentralised approach entails cost containment and efficiency measures. The efficiency derived from primary health care is maximised when the net cost of organising primary health care is minimised (point N_1 in figure 3). The decisions of localities emerge from a rational collective choice. Local citizens are provided with a choice, and the choice amongst alternative collective units limits both the external costs imposed by collective action and the expected costs of decision-making. This suggests that primary health care should be organised in small rather than large units.

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The degree of homogeneity among the voting community influences both decision-making costs, and external costs. In a *homogenous* community individuals have identical preferences, there is less uncertainty about tastes, skills and need. The particular chemistry of contact of individuals with a shared vision, and their particular mix of creativity and technical expertise, will lower decision-making costs. Less will be invested in bargaining since the collective compose of roughly homogenous members which would make it relatively easier to reach broad consensus on fundamental primary health care matters. External costs can be expected to be little or zero, for there would be few/no minority. A *homogenous* community decreases costs, lessens conflict and leads to voluntary

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co-ordination as it influences collective action by increasing the number of social ties and norms that people can draw upon in building co-operation.

In a *heterogeneous* community, individuals identify with many groups, and preferences, status, and class positions are different. Decision-making costs would be high, as certain groups would feel disadvantaged or excluded from the final decision taken. As societies become more heterogeneous, it becomes more complex, and central control and decision-making becomes more difficult, costly and inefficient.

The local authority institutions have a potential comparative advantage in efficient participatory provisioning of primary health care services since it provides the institutional mechanisms[3] through which citizens can participate and express in a systematic and exceptionally effective manner their preferences and perceived problems. Through established[4] channels and safeguards it provides the local community with the space and institutional bargaining power to articulate and protect their vested interests and foster community solidarity and ethos (Lyons, Smuts and Stephens, 2000:63). Demand articulation and demand satisfaction at the local level are in greater accord and the degree of consensus among decision-makers and between decision-makers and their constituencies is likely to be higher.

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The White paper, (1998:14,20,27) states that the local authority is uniquely placed to analyse the power dynamics and divisions within a community and to ensure that those who tend to be excluded and marginalised can become active and equal participants in community processes. Participation, in terms of elections and interaction between elections with local government officials can be substantially

[3] Azfar, 1999 identifies several institutional mechanisms such as elections, surveys, town meetings, local referenda, direct community involvement, demonstrations and formal redress.
[4] Section 16(1) of the Systems Act requires municipalities to develop a culture of municipal governance that complements formal representative government with a system of participatory governance. In terms of section 17(2) of the Systems Act, municipalities are obliged to establish appropriate mechanisms, processes and procedures to enable the local community to participate in the affairs of the municipality.

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enhanced. Policies are adopted from within after a process of consensus building on basic tenets and are not imposed from outside (Stiglitz, 1999). The community is able to determine whether the kind of service they received meets their expectations and they are able to articulate this to decision makers. The impact of citizen voice is maximized as it can be expressed to the top of the chain of command and deliberations can take place at the highest possible level.

An improvement in the health status of an individual enhances the participation of individuals in the political processes and local decision-making and therefore enlarges the effective political majority with a voice on redistributive polices and issues where voter preferences matter. Participatory decision-making helps to strengthen democracy and ensure that majority needs and goals are heard as it provides the means for demand revelation and helps to match the allocation of resources to user preferences. Political decentralisation offers greater political participation and as hypothesised above, should give more voice to the people closer to the local authority. Fuelled by local participation, the local authority might make decisions that represent the interests of the constituents and hence the relevance and effectiveness of primary health care outputs and outcomes. Maximum citizen participation, in the sense that all intended participants have a voice, can ensure that there are always responsiveness to community needs and leads to more constructive future dialogue, co-operation and credibility. Participation, interaction and unity of the citizens of the region will lower external costs. Regional welfare can be enhanced and greater efficiency achieved.

Participation made local authorities more accountable to citizens by increasing the political costs of inefficient and inadequate public decisions (Stigligh, 1999). The community and its precursor social capital enable citizens to articulate their reaction to the local authority and to lobby officials to be responsive and accountable. It is more cost-effective if transactions take place in an environment of trust as the likelihood of co-operation is greater. Social mechanisms are more efficient than legal enforcement mechanisms. Shared civic norms and the prevalence of trust among the local population, and between citizens and elected

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local representatives affect service delivery by decreasing the cost of acting collectively and, thereby, facilitating co-operation and collective action. A society with established long-term relations where community members trust one another to keep agreements and use reciprocity in their relationships with one another faces lower expected costs involved in monitoring and sanctioning one another over time. The lower decision and external costs at the local authority releases resources for application elsewhere in the economy.

Efficiency is further enhanced by consumer mobility. When voicing mechanisms do not exist or are ineffective and primary health care service provided does not meet expectations, citizens have the option to stop using the service either by switching to alternative service providers within the same jurisdiction (Azfar, 1999) or by moving to another jurisdiction (Tiebout, 1956). Charles Tiebout (1956) has argued that a member of the collective can to some extent select as his place of residence a community that provides a primary health care package that best satisfies his preferences and thus vote with their feet. This option assumes spatial variety in primary health care policies and quality so that moving makes people better off. This is besides the voting option whereby an elected representative is voted out of office when he deviates from the aggregate preferences of his constituency. Potential inter-jurisdictional migration, availability of alternative providers, heath risk and voting thus constrain government behaviour from deviating too far from voter preferences. Further, the feasibility of moving to another jurisdiction depends on the mobility of labour and capital (Azfar, 1999). Whether citizens can exit by switching service providers in the same jurisdiction depends on the existence of the quality of and confidence in alternative suppliers.

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B. Allocative efficiency 2: budgetary allocation

Allocative efficiency requires that expenditure allocations are consistent with priorities.

Preference Differentiation

The demand for primary health care is not uniform across the country and/or consumers might not reveal their demand for primary health care. Since primary health care is a merit good and generally impure, providing it efficiently is more flexible. A decentralised fiscal management system provides ample scope for the variety and differences pertaining to the preferences of geographical subsets of the population by allowing various processes and various kinds of plans/products for various localities. It facilitates spatial variety in the mix and level of primary health care as allowances can be made for communities to express cultural and curative preferences (Ahmad, in Ter-Minassian, 1997:25) to the extent that the local authorities adjust their expenditure and revenue raising patterns to the collective preferences of their own constituents (Ajam, 2001).

The economic benefits of local service provision are captured when budget decisions are made. Decentralisation has the potential to improve the aggregation problem by allowing a closer match between the preferences of the population and the mix of public goods provided through the government budget. If preferences are heterogeneous across jurisdictions, the local authority as decision maker can tailor the mix of goods and services to better suit the preferences of the population instead of providing a "one size fits all' for the country as a whole. The allocation of good and service demanded by the median voter will be more tailored to the needs of the majority. To the extent that preferences are aggregated among a smaller and more homogenous group, the social outcome should result in improved resource allocation.

The collective, seeking to maximise the welfare of its own constituents, will provide an efficient level of output, as marginal cost of the local residents will be equated to the marginal benefits. The greater flexibility of the local authority in

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adapting systems, procedures and finances to local needs and conditions (Ter-Minassian, 1997:16) create a better balance between demand and supply in the area of primary health care (Ehtisham Ahmad, p25 in Teresa Ter-Minassian, 1997). The better matching of primary health care services to preferences and circumstances of local constituency implies an increase in the output of resources and improvements in the quality of the services. Maximisation of output for any given input leads to cost savings. Regional welfare can be enhanced and greater allocative efficiency achieved because residences in different jurisdictions could choose the exact mix of primary health care services through the collective decision-making process based on local demand and preferences. Making the local authority more successful in providing appropriate levels of output than the national government.

A decentralised approach permits choice and greater efficiency in consumption as well as greater efficiency in production. This hinges on the ability to make well-informed and intelligent choices:

Information

The external environment influences the internal dynamics of primary health care management. Given constant environmental change, the government needs to be aware of the skills, techniques and approaches that yield appropriate levels of primary health care service. The superior information (Abedian, et al., 1997:100) about local preferences at the local authority and the specific features of primary health care information could enhance allocative efficiency and may cause the local authority to be more superior than the national government. The local authority has more information about the consumers of primary health care, and they can better leverage that information for solving many of the day-to-day problems facing the community. Increased information about health care needs, practices, and activities gives them real power. The local authority is in a better position to make informed trade-offs concerning primary health care provisioning and the promotion of sustainable primary health care developments, since they are expected to possess better information about local preferences.

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The presence of frequently available, reliable indicators about the conditions of primary health care increase awareness of local needs and early warning of emergencies; help in tracking key health system indicators; and allows for much faster tracing of outbreak patterns, accelerate decision-making, reduce data processing costs and facilitate improved communication. Up to date information is needed about how actions will affect the government budget. The local authority should be better informed about the detailed needs of the constituent members because of the closer contact with the electorate. The local authority faces lower decision costs in gathering and aggregating place-specific information. Informational requirements at central level may be costly.

The proximity of the local government to their constituents facilitates the exchange of information between the government and the local population about region specific needs and thereby reduces asymmetric information. Asymmetries of information provide the fundamental reason for inefficiencies that arise out of the information assumptions. Major illnesses also impose large risks and costs. The increased flow of information from the local area raise the capacity of the government to adapt relatively soon to changes that could adversely affect their long-term budgetary resources. They may be able to meet multifaceted demands as local conditions are understood and institutional opportunities and constraints are identified. Allocative efficiency is improved because local authorities have a better understanding of the local demand for public goods and services, and are able to allocate scarce resources to better match this demand (Humplick and Moini-Araghi, 1996), thereby increasing satisfaction and welfare.

Responsiveness

The local authority, operating closer to the citizens in the region, in both the spatial and institutional senses, will be more knowledgeable about and hence more responsive to the needs of the voters. They are better placed to respond to local level dynamics such as variations in conditions, tastes, standards, location and requirements for primary health care services and infrastructure. It is better placed

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to achieve outcomes that are more responsive to local needs, priorities, and preferences in both the allocation of budgetary resources and the delivery of primary health care services by enhancing the speed, quantity and quality of responsive actions (Ehtisam and Baer, 1997:459). It can react more closely to what residents wants and is therefore considered to be more effective in meeting the local needs.

Having greater flexibility and the means to act quickly they respond to external demand focussing on the response of individuals to changes in the health system and advances in technology that have implications for primary health care. The inherent cost (it is the cost incurred by primary health care users due to the inability of government to meet user preferences of primary health care quality) resulting from a lack of responsiveness of government to the local demand for primary health care may be high.

Decentralisation permits an equitable arrangement. The informational advantages of local provision predominate when there is a need for fine targeting as with primary health care. The link with local level of resources at the margin is also clear. The local authority can better address causes rather than just allocating capital expenditure for dealing with isolated symptoms and treatment. Good use of local information, local manpower and resources, can help in identifying more effective and efficient ways of building infrastructure or providing primary health care services where it is most needed and subsequently of organising their operation and maintenance. Resources could be targeted and directed to selected areas at realistic quantums in response to identified development problems and opportunities pertinent to the community (The World Bank, 1989:71).

Population Changes

For primary health care, characterised by differing degrees of publicness, it could be expected *a priori* that if population increased, and furthermore if the level of output consumed by each member of the group was to remain constant, then an increase in population would result in a less than proportional increase in

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expenditure as the demand for primary health care is elastic. For those services that have surplus capacity, a population change, which simply takes up the slack in the system, will result in a less than proportional increase in expenditure.

Direct Impact

The direct impact of population increases can be summarised in a crowding function as illustrated in Brown, p 139.

$A_k = X_k / N^{\alpha}$

where A_k are the utility services for the kth public good G_k;

X_k are the activities (facilities) used to produced G_k,

N is the size of the population and α is a crowding parameter.

For a pure public good $\alpha = 0$; for a private good $\alpha = 1$, i.e. adding more consumers reduces utility, for mixed goods $0 \angle \alpha \angle 1$.

Indirect Impact

Population increases can place strain upon service conditions. As the population increases, the population density may also increase, with a resultant increase in the social costs of congestion. These congestion costs influence in a negative way the individual's utility such that additional resources would be required in order to make each individual just as well off after the change in population as before the change. If one assumes that the level of output and quality of the service remain constant, the existence of external costs of congestion, will lead to a greater than proportional increase in expenditure.

Accountability[5]

The local authority possesses distinct advantages in accountable provision

[5] According to Ribot J, 2001, accountability is the exercise of counter power to balance arbitrary action which can be divided into answerability and enforcement. Answerability constitutes the obligation to provide information and explanations concerning decisions and actions. Enforcement is the ability of the collective to apply sanctions if they don't like the answers they are getting.

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of primary health care. Accountability comes in two dimensions:

1) The accountability of elected representatives to their constituents (between elections). This is where the collective evaluates and sanctions the record of the politicians. Physical proximity in principle makes it easier for citizens to hold elected representatives accountable for their performance. Residents have direct access to the local representatives, and to the local administrations, which cover confined geographical areas. There are therefore more direct mechanisms of accountability within local authorities. Sanctions can be imposed on defaulting or free-riding community members. Social sanctions are hard to ignore and can be used to enforce good behaviour, partly because such individuals identify with the community and its concerns and because of the longstanding relationships involved.

2) ***The accountability of local civil servants to elected representatives.*** Local authority managers are under continuous scrutiny by politicians, the latter being expected to be the custodian of public interest. This is more problematic since the elected representatives do not have formal supervisory authority over the civil servants and their loyalties may lie elsewhere. Also, civil servants, often have considerable incentives to evade control by locally elected officials. This is a greater concern in governments at national level where jurisdictions are large and populous, and face-to face contact is harder, than in small populations.

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Making local officials more accountable and placing responsibility for decision-making and implementation in the hands of local stakeholders, improves the quality and efficiency of public services. In addition to increasing awareness of budget constraints and the need to shape political demands accordingly, local leaders can be held accountable for performance. This act as an incentive for prudent fiscal behaviour as budgets can be monitored in relation to quality of life. One of the mechanisms whereby monitoring takes place is through local elections. Through the local elections voters can retain or reject their local representatives. The local community has a stronger incentive to verify that the programs are reaching the citizens.

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Information requirements and transaction costs are lower at lower levels of government and the government can be more responsive and accountable to the citizens of the region. Lack of accountability may lead to uncontrolled growth of public expenditure. For allocative as well as distributional reasons, the decentralisation of primary health care is desirable and it is likely to maximise the health gains for a given budget.

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C. Operational efficiency: budget administration and management

This section examines the hypothesis that there are management and administrative efficiency advantages to local supply of primary health care, such as improved management capacity and possibly better quality through local supervision.

The institutional context of decision-making

Under a **centralised administration** there are uniformity of procedures, which would promote consistency and reduce compliance cost. It may also permit economies of scale, particularly in the utilisation of computer hardware and systems (Ter-Minassian, 1997). A **decentralised administration**, on the other hand would entail greater responsiveness and accountability of local authorities for primary health care provisioning, as well as greater flexibility in aligning budget processes and planning to local circumstances. The way decision powers are held, divided and amalgamated affects both external and decision-making costs if institutional change and impacts on both efficiency and equity factors. Different resource commitments and the allocation of infrastructure and amenities affect the cost and quality of life.

As a result of the diffusion of power, the institutional context in which decision-making takes place changes. Decentralisation shifts the locus of decision-making to lower levels of government. This allows the lower levels of government choice over the extent of service provision, the priority of the service, and the manner of delivery (Financial and Fiscal Commission, 2002). This alters the underlying objective and incentive (reward) structure which influences decisions about service provision, planning and implementation, accountability, financing and the distribution of services between groups in society (Abedian, 1998). Decision-making takes place in line with or is informed by the choices of the constituents. This strategy supports and focus on local issues, and other, larger and more controversial national issues do not obscure development and decision-making

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(Gildenhuys, 1991:114). Health plans can be based on locally identified needs and cultural and curative preferences. It is a bottom-up approach that seeks to re-orient the development process away from top-down tecnocratically planned interventions.

Local authority primary health care administration provides more flexibility with respect to organisational structure and personnel practices than a centralised one. Priority scheduling becomes much easier as it entails a flexible process of re-prioritising and restrategising to meet the challenges of a dynamic and rapidly changing operating environment. It provides scope for innovation with regards to improved and integrated planning and budgeting procedures and a pro-active management approach. This strategy provides managers with the freedom to optimise resource mix and managerial authority can be exercised more effectively and increased demands met timeously and comfortably. The decision-making process is flexible enough to accommodate the additional costs incurred by the local authority within the same time-frame in which the expenditure is incurred.

The local authority has smaller bureaucracies and the lines of authority and communication are normally shorter. Decisions are closer to line managers (Mokgoro, 2002:166), which allows for greater bureaucratic control at the local level. Micromanagement improves the bureaucracy's capacity for planning, and service delivery. Local authorities focus on narrower missions and regulatory activities embedded in bureaucratic organisations become more distinct and explicit. The lower variability of decision quality (Stiglitz, 1999) allows fewer good projects to be rejected and the budgetary burden on society decreases. Since the local authority has the freedom to exercise independent fiscal management, they retain the ability to adjust (reduce spending or raise taxes) to macroeconomic shocks in a way that prevents the local authority spending beyond their means. There is thus better alignment between policies, budgets and implementation. Better alignment in the process itself as well as the outcomes. Attributes of simplicity go along with feasibility. By reducing diseconomies of scale inherent in the over-concentration of decision-making, decentralisation to the local authority

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can increase the number of public goods and services – and the efficiency with which they are delivered – at lower cost. It has a multiplier effect – maximise limited resources- optimise on health, overall well-being, job opportunities, development and economic growth. This will in turn lead to increased access to primary health care services through increased efficiency in decisions to address quality improvements in primary health care issues. It can help government reach larger numbers in local areas with services.

Decentralisation helps cut the complex bureaucratic procedures and thereby alleviate the bottlenecks in decision-making that are often caused by national government planning and control of primary health care activities. It will place the local authority in a position to design and implement projects without the cumbersome procurement procedures of the national government. Thereby speeding up the making and implementation of decisions. Decision-making at the local level gives more responsibility, ownership and thus incentives, to local agents, and local information can often identify cheaper and more appropriate ways of providing primary health care services, leading to improvements in the quality of services. Efficiencies in investment and operation will ultimately translate into greater numbers being served and/or lower user charges for any given quantum of investment. Basic primary health care services can thus be provided at a lower cost.

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The local authority provides the right incentive structure (incentives to control cost) for efficiency and quality service delivery. Incentives create opportunities to control cost and influence both equity and efficiency. They have incentives to identify public programs that will benefit many people, alienate few and, if possible remain sustainable. Services can be located and facilitated more effectively within the community and can therefore, be considered more sustainable.

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A decentralised system operationalises an integrated planning philosophy. In the opinion of Braslavsky, 1999, the distribution of power from the apex of a system organised as a hierarchical pyramid to the base and from the summit to the grass roots can release a strong individual and collective creativity that will make it easier to achieve a more improved and integrated primary health care service. Primary health care service with its multiple dimensions is part of a nexus of social services and their provision fits into complex relations. The local authority can co-ordinate primary health care services more easily than could the national government (The World Bank, 1989:71). The local authority provides an institutional setting that promotes greater opportunities with respect to implementing a more comprehensive and unified primary health care service. The local authority is better placed for meshing technical and other inputs with the local information and organisational capacity of the community. Programs, line department staff, budgets, activities and resource utilisation of existing entities can be better co-ordinated, and so to ensure complementary rather than competing activities.

It is well positioned to harness, co-ordinate, and employ an integrated strategy in its relations to other spheres of development such as economic, infrastructure and social development. The local authority is in a much better position than the national government to provide interventions, which are most cost effective in providing a comprehensive approach. A comprehensive approach to primary health care focus on all the factors that affect health; including programs that improve knowledge, childhood nutrition, access to clean water, sanitation, vaccinations (involving large externalities). A comprehensive and integrated approach to primary health care achieves real gains in the health and overall well being of the population, improve deployment of resources, improve response time and reduce time to treatment. Integration leads to simplification of the system by minimising compliance and administration costs (and the related efficiency losses).

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Decentralisation implies an autonomous, self-financing administration. It is easier for locally based institutions to levy and collect user fees, because of the more evident returns by those who pay. It thus allows for a closer correlation between expenditure patterns and real resource cost as the jurisdictions are smaller. Closer linkage of the benefits of local authority's primary health care services with their costs helps to promote accountability. Local officials become more accountable, as a clear link is established between local decisions to raise revenues and to incur expenditure (Vehorn and Ahmad in Ter-Minnasian, 1997:117). By increasing accountability, it also encourages the local authority to improve their managerial capacity. These improvements will in turn lead to increased confidence in the ability of the local authority to function in their own right.

Local monitoring of the provision of primary health care services may be more effective than national monitoring. Local information and peer monitoring reduce monitoring and reporting costs, contribute to diversifying monitoring mechanisms and incentives for local authority performance, increase the efficiency of regulatory functions and strengthens the lines of accountability. Efficiency in the supply of monitoring requires that effort be expended in monitoring up to the point where the marginal collective benefit equals the marginal cost (Gunning, 1997). A member of the collective has an incentive to monitor to the point where marginal personal benefit equals marginal cost. The marginal cost of monitoring may effectively be zero, since such monitoring may be a by-product of other activities (Stiglitz, 1999).

Budget Transparency

Information on budgets and on the use of funds is easier to obtain from the local authority thus increasing the transparency of public actions and reducing corruption. Transparency of public actions induces cost consciousness. Transparency in decision-making and public access to information can be a powerful tool in reducing the influence of special interests and improving government performance. It increases the cost of the more outrageous forms of special interest.

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The particular form[6] and degree of local authority autonomy have important implications for the management and cost of decentralised primary health care provisioning. Legal factors influence decision-making procedures and shape the treatment of key issues in the legal and regulatory framework of primary health care. The constitution, laws and regulations codify the formal parameters in which primary health care services function. A local authority that has little autonomy may face high decision-making costs as those who disagree with locally developed rules may seek contacts with higher-level officials to undo the efforts of the local authority to achieve regulation. With the legal autonomy to make their own rules, the local authority faces substantially lower costs in defending their own rules. When the rights of the local authority to devise their own rules are recognised by all participants, rules will be less frequently challenged in the courts. By adopting statutes and selecting the correct structure[7] for fixing responsibility for primary health care, costly changes can be avoided and the relative durability of the rules ensured. Making the rules explicit and reasonably permanent, removes any ambiguity about what policy should be set. The location of the responsibility for meeting the targets can be well defined and hence anchors health expectations. It also provides a common ground for all the citizens in the political process. The smaller size of the constituency at the local level makes co-ordinating legislative action easier (Opeskin, 1998). The greater the responsibility given for legislating and implementing their own programs, the more accountable will they be to their citizens through the political process.

The distribtuional implications of the quality of primary health care

Small geographical areas may be at a disadvantage due to economies of scale in health care industries and administrative capacities. Since the geographical boundaries of the local area are smaller, key jurisdictional issues can be more

[6] Rondinelli, 1981, distinguishing between three major forms of functional decentralisation,, namely deconcentration, delegation and devolution. Each form of decentralisation has different implications for institutional arrangements, the degree of transfer of authority and power, local citizen participation and efficiency.

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easily identified and addressed through direct policy measures and more focused services. Small boundaries have better, coherent fiscal institutions and show better performance in targeting those that really need the services. Those who have the greatest capacity to benefit from health services would receive the service. The local authority is better able to identify target groups and to mobilise support for them.

Decentralisation improves the capacity of the local authority, allowing them to develop sophisticated targeting mechanisms. The combination of better staff and better data increased the level of sophistication at the local authority, allowing them to meet specific primary health care requirements.

[7] constitution, law or regulation

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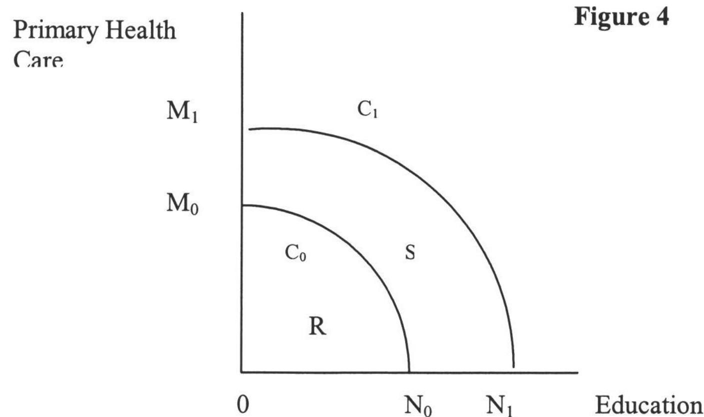
D. Dynamic efficiency

The local authority may have greater flexibility and potentially greater opportunities for innovations, experimentation and learning; without having to justify new policies and programs to the whole country (Rondinelli, 1981). Small bureaucracies are often superior in both producing and commercialising new inventions.

Versatility and the ability to provide creative solutions to problems promises greater technical progress for providing primary health care services in the long run. This coupled with the increased competitive pressures from neighbouring jurisdictions, will lead to the adoption of the most efficient techniques in primary health care, which in turn result in improvements in productivity and a decline in real prices. The mobility of people amongst jurisdictions (Tiebout, 1956) can create competition among local authorities to better satisfy citizens' needs. These pro-competitive effects promote price and dynamic innovation efficiency (Oates, 1972) in the provision of primary health care. We could assess through the estimation of a production frontier the efficiency gains to be achieved from a decentralised setting (technical). The net effect can be shown as an outward shift in the production possibility curve from M_0N_0 to M_1N_1 in figure 4, and by a concomitant change in the competitive equilibrium, for example, from point C_0 to C_1.

Figure 4



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On a static level, more competition should increase the elasticity of demand faced by incumbents forcing them to lower their mark-up of prices over costs. It should also remove any X-inefficiency (such as point R in figure 4) in the operations of the incumbent, enabling costs to be reduced (Hodge, 2000). Reforms that improve primary health care efficiency are expected to cut total costs and hence improve the overall competitiveness of the economy of the region.

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SECTION IV

PRIMARY HEALTH CARE IN THE METROPOLITAN AREA OF THE WESTERN CAPE

This section provides a situational analyses of primary health care in the Metropolitan area of the Western Cape for the period 1996-2000. Historical, political, institutional and legislative embeddedness of primary health care are accounted for.

Historical Background

Nationally, the country is characterised by substantial regional disparities in the distribution of productive resources and incomes, and the ability of lower levels of government to provide primary health care services vary widely. Historical and societal traditions of the Metropolitan Area of Cape Town have provided the foundation for a decentralised primary health care system. The Cape Metropolitan population was estimated at 3 053 700 – mid 2000[8]. Not only are they clearly differentiated in terms of cultural pattern and historical distinctiveness in relation to other groups and situated in a more or less identifiable territory, they also clearly displays a will to maintain its distinctiveness in the political sphere. Due to the size of the citizenry, the internal relationships tend to be manageable. However, nationally, internal relationships tend to be organic, dynamic and uncertain.

At the micro level there is a rich endowment of social capital - local experience, rich cultural heritage, dense personal and community ties, networks, trust and support, and emotional belonging that have created a high degree of uniformity. Each of these social capitals has an intrinsic value that would enhance the capacities of the community for collective action. Collaboration among citizens can be enhanced to develop appropriate strategies to address local problems and constraints. Collective action creates social capital. Each application, rather than diminish social capital, augments it (Stiglitz, 1999). Social networks support innovation in primary health care. Trust in these relations is especially important

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[8] Wesgro. Western Cape. Business Prospects 2002.

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as it improves the quality of information exchanges and encourages the development of strong intra-community ties (Murphy, 2002:591). This relative and social homogeneity of the local population makes it easier for people to work together and therefore for the political process to arrive at co-operative solutions to problems; thereby increasing the efficiency of resource allocation and public service delivery.

Between 1997 and 2000 the Cape Metropolitan Area contained within it six Metropolitan Local Councils (Blaauwberg MLC, Central Cape Town, Helderberg MLC, Oostenberg MLC, Southern Peninsula MLC, Tygerberg MLC). These metropolitan local councils neither met their intended purposes nor was it consistent with the culture and needs of the local people. It did not promote self-determination and the creation of a more democratic participatory efficient and development oriented government. Each had a strong inward orientation with its own economic development responsibility. Each region treated its area as a distinct entity with its own development potential, resources and strategic development (Wesgro, 2002). There is thus already a solid historical record of local government, so there is a base of experience to build on. The fact that the community and the local government exist indicates the presence of some skills. Previous experience with other forms of local organisation greatly enhances the repertoire of rules and strategies known by local participants as potentially useful to achieve various forms of regulation. Citizens are more likely to agree upon rules whose operation they understand from prior knowledge and experience, than upon rules that are externally imposed and are new to their experience.

In 2000 the metropolitan has been established as an autonomous[9] region with exclusive municipal executive and legislative authority in its area. The Local Authority in the metropolitan area of Cape Town have undergone substantial restructuring, since 1994, not only with the advent of democracy, but also since, with revised boundary demarcations, spheres of responsibility, and methods of

[9] Act 108 of 1996, The Constitution of the Republic of South Africa, section 155; Provincial Gazette Extraordinary. No. 5431. Provincial Notice 69 of 2000. 3 March 2000, and The Provincial Gazette Extraordinary No. 5588, 22 September. 2000.

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service delivery. The restructuring provided a greater scope for innovation with regards to improved and integrated planning and budgeting procedures.

The primary health care system

The primary health care system inherited in 1994 was characterised by highly centralised financial decisions and fragmented service provisioning. Financing, planning and management were control-oriented, and imposed from the top levels of government downwards, with inadequate recognition of the diversity of the region. The centralised system of primary health care has resulted in dependent local governments - politically, financially and administratively.

Primary health care service provisioning is fragmented between a number of field of services, levels of care and institutions in close proximity to each other. See Annexure 1. Each of these facilities has their own procedures, approaches and priorities and do not allow for a holistic approach. Work is not integrated, but compartmentalised. Decision-making and planning for primary health care are mixed between spheres of government. There is little relationship between plans, available funds and actual implementation. The paper by McIntyre (1998) showed that the planning systems between the different levels of government show no evidence of the integration of local integrated developed health plans into provincial or national strategic plans and budgeting. Investment plans and budgets for capital expenditure (such as new clinics) at provincial level are not linked to the recurrent budgeting processes for nurses and health care equipment at the local authority level.

The main strength of the provincial facilities lies in its human resources – the key cost drivers for primary health care expenditures. The human resource component of the Provincial Administration of the Western Cape presently comprises a personnel corps[10]of approximately 1858 primary health care workers whereas about 1369 health care workers are employed by the Local Authorities. The local authority facilities are generally nurse driven and the provincial facilities are

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generally doctor-driven. These facilities do not share their resources because of the differences in governing authority and the significant disparities in conditions of employment, salary scales and other service benefits.

Primary health care expenditure efficiency and service quality have deteriorated as a consequence of fragmented, artificially separated and uncoordinated management. This has been exacerbated by a lack of clear delineation of primary health care responsibilities in the constitution and the extent to which executive functions are exercise by provincial and national government departments. The structural separation and number of agencies in control of primary health care and the timing of their interventions change the outcomes of primary health care. This is so as the goals and incentives of the different institutions and spheres of government are often not compatible. Administrative processes and structures are also different. The larger the number of agencies controlling primary health care, subsidising or monitoring it, the greater the inefficiency. Dismantling existing rigidities can unleash forces that will both provide more efficient care with lower costs and more efficient and equitable services.

Constitutional and Legal Aspects

Powers are derived from the Constitution and are not delegated from the national or provincial government (Mettler, 2001). This changes the institutional landscape of the local authority and the way primary health care services are to be delivered. The fundamental status, financial independence and purpose of the local authority[11] are entrenched in the Constitution, leading to laws and regulations covering specific implementation of primary health care services. These laws and regulations affirm the powers and functions of the local government and define the specific parameters of the intergovernmental fiscal system and the institutional details of the local authority structure, including key structures, procedures

[10] Statistics from the Report of the Bi-ministerial task team on the implementation of a municipality-based district heath system, p14.

[11] Section 153 (a) of the National Constitution, 1996 states that a municipality must structure and manage its administration, budgeting, and planning processes to give effect to the basic needs of the community, and Section 154 (1) (b) stipulates that national and provincial governments, by legislative and other measures must support and strengthen the capacity of municipalities to manage their own affairs.

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(including elections), accountabilities, and remedies within which primary health care are delivered.

The Constitution of the Republic of South Africa, Act 108 of 1996 granted an unparallel degree of autonomy to the local government sphere. Some stability in the attribution of tasks is thus introduced that avoid the political transaction costs of continually reassigning tasks and redefining institutions. This implies that the Local Authority is free to establish its own procedures for government, including at least in theory, the right to establish and administer its own taxes.

The overall legislative framework for local government and primary health care is captured in the following legislation.

- **The Municipal Structures Act** consolidates a complex system of transitional governments into three municipal categories.
- **The Municipal Systems Act** regulates internal municipal arrangements.
- **The Municipal Demarcation Act,** attempts to increase the viability of local governments by consolidating the municipalities.
- **A new property Rating Bill** is expected to expand and improve property rates.
- **The local government white paper published in March 1998** describes the duties of the Local Authority.
- **The National Health Bill**[12]**,** provides a regulatory framework that establish a legal foundation for the transfer of powers. It makes the local authority the administrative focus of primary health care functions. This created substantial impetus to a comprehensive primary health care service in a geographically defined area run by a single authority.
- **The Health Act No. 63 of 1977** allows for joint provincial and local government provisioning[13] of primary health care.

[12] The National Health Bill, 2001 is to be tabled in parliament in 2002. Sections most relevant for present purposes are Section 4-46, and section 54. Section 43 also defines Municipal health services.
[13] See section 16(1), Section 20 and section 20 (1) (d).

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- The **Local Government Transition Act (Second Amendment)** prescribes that " municipal health services are to be delivered by the Metropolitan Local Councils"[14] in the Metropolitan Area.
- **The Municipal Finance Management Bill** defines financial management systems, establishes a debt framework, and allows for monitoring municipal fiscal conditions. It is aimed at securing transparency, accountability and sound management of the revenue, expenditure, assets, and liabilities of the municipalities.
- The primary purpose of **The Public Finance Management Act of 1999 is** to regulate financial management in the provincial government, to ensure that all revenue, expenditure, assets and liabilities are managed efficiently and effectively, and to provide for the responsibilities of persons entrusted with financial management.

Constitutional provisions protect the autonomy[15] of the local authority and the constitutional structure results in a process of public decision-making in which local interests have a relatively major impact on choices affecting primarily the electorate. Efficient and politically accountable provision for primary health care services is thus facilitated and the cost of organising (decision-making cost) is lowered.

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Legislative and constitutional authority for primary health care services indicates significant degrees of joint[16] provisioning. The Constitution, 1996 identifies "Municipal Health Services" as a local authority function and "Health Services" as a provincial function. The constitution does not define municipal health services and refers to both health services and municipal health services. The

[14] This is in accordance with the constitutional requirement to grant provinces the right to allocate resources according to locally determined priorities.

[15] Section 151(3) of the Constitution gives municipalities the powers to govern local government affairs subjected to national and provincial legislation. The national and provincial spheres are however constrained by Section 151 (4). They are expressly prevented from compromising or impeding a municipality's ability or right to exercise its powers or perform its functions. This is in accordance with the obligation as set out in Section 41 (1) (g) where all spheres are called upon not to encroach on the geographical, functional or institutional integrity of government in another sphere.

[16] Health Services (Part A) and Municipal health services (Part B) are listed in Schedule 4 of the Constitution entitled "Functional Areas of Concurrent National and Provincial Legislative Competence". Functions as listed in Part B of Schedule 4 are uncontested local government responsibilities.

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Health Act (63 of 1977) allocates some aspects of primary health care to Local Authorities and others to the Provincial Health Departments[17].

There is nevertheless an inherent contradiction and tension in the manner in which the power sharing arrangements have evolved, whereby in practice the national government determines the policy and norms and standards in the various functional areas, while provincial governments are responsible for implementation. When policy decisions taken at national level have major cost implications for the implementing agencies, the potential for destabilising the entire intergovernmental fiscal system becomes great in the absence of the extensive consultation and co-ordination envisaged by the Constitution. The constitution does not spell out precisely how these concurrent responsibilities are to be shared. A fragmented and partial form of decentralisation keeps central power strong and prevents the consolidation of any possible ethnic or regional power bases.

The Constitution, section 155(6A)[18] allows for a reorganisation of the local authority territory in order to ascertain that areas are large enough to provide the functions incumbent on them efficiently. A more homogenous entity could thus be created that require fewer resources. Administrative costs could also be reduced (Paul Berndspan and Wolfgang Föttinger, in Ter-Minassian, 1997:247).

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Financial Capacity

A local authority should have financial capacity to function properly. Financial independence indicates that the local authority has the desired capacity to carry out a decentralised primary health care function. It allows the local authority to exert an influential role within the realm of its own jurisdiction. Financial autonomy tends to lower the cost of organising.

[17] Section 16(1) of the Health Act gives the responsibility for the provision of curative primary health care services to the provinces. Section 20 gives this same responsibility to local authorities. See also section 2(1)(d).

[18] See also Local government cross boundary municipalities Bill. 2000.

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The local authority in the Metropolitan Area of Cape Town has been assigned revenue generating municipal services and rely heavily on the revenue raised from water, electricity, the imposition of property taxes and levies on turnover/payroll - the Regional Service Council levy and transfers from the national and provincial spheres. It generates approximately 90 percent[19] of its revenue internally. Trading services generates the bulk of the revenue. Property tax collection yields good results since the main economic activities are concentrated and developed in the metropolitan area and the degree of urbanisation is higher. Resources from the property tax have supported institutional strengthening; it can therefore be argued that it has improved performance - both financially and in the provision of primary health care services. In this sense, the local authority in the Metropolitan Area has reduced its independence on transfers and demonstrates capacity for self-reliance.

The majority of primary health care expenditure is however, funded from general tax revenue. Local government property rates, taxes and utility sales contribute a very small proportion to primary health care financing. The over-reliance on national funding could undermine fiscal autonomy. Breaking the link between those who raise revenue and those who make spending decisions could dilute fiscal accountability (since there would no longer be the political constraint of justifying expenditure patterns to local electorates). It could also induce perverse incentives such as inefficient increases in expenditure, since costs would be shifted onto national government, as well as deviation from electorate preferences. The current system has created a culture of dependency and is incurring costs that are no longer sustainable.

The issues dealt with by the local authority in the Cape Metropolitan Area, are relatively few and clearly defined, and the constituency is relatively homogenous, leading to a greater degree of consensus in decision-making, and a greater degree of citizen satisfaction with the local authority. Also, over time, the local authority became increasingly homogenous internally, which lowers decision-making costs

[19] Cape Metropolitan Councils' Annual Financial Statement for the years ended 30 June 1999/2000.

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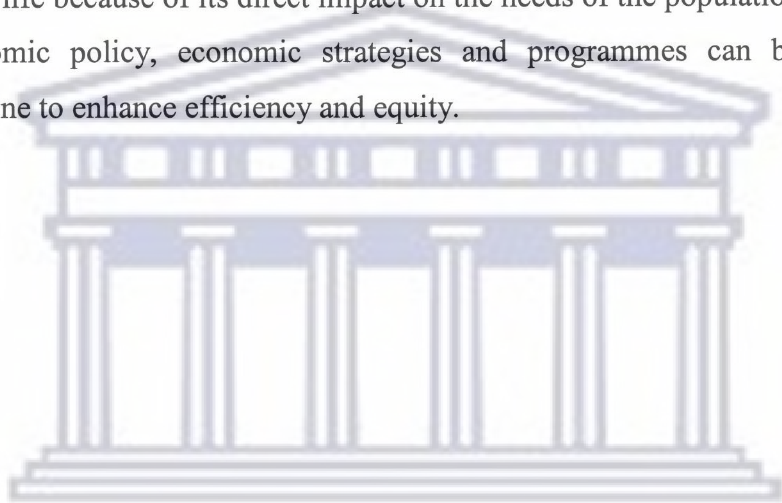
and minimises damage by exclusion to minority groups (Vosloo, 1979 in Gildenhuys, 1991:chapter 1). There is also a viable structure of legal and financial auditing by the central government, which enforces and makes the Local Authority more accountable.

The Local Authority creates a conducive environment to exercise its power and functions in a way that has a maximum positive impact on social and economic development and on the quality of life of its citizens. It makes the pursuit of a better life because of its direct impact on the needs of the population in the region. Economic policy, economic strategies and programmes can be more easily combine to enhance efficiency and equity.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SECTION V

CONCLUSION

There are both efficiency and equity advantages in a decentralised system as the better guarantor of effective government than a centralised system. The twin forces of equity and efficiency provide a prima face case for the local authority to provide primary health care services in the Metropolitan Area of Cape Town.

The rich base of social capital creates a comparative advantage for the local authority since it can benefit form the spin-offs created by the focus on a comprehensive primary health care service. The Cape Metropolitan Area can build upon a wide range of existing resources, experience, and expertise. Conducive conditions, relatively untapped economic potential and the highly progressive legal and institutional framework, provide a strong enabling environment for decentralisation. Constitutionally, provision is made for service provision of primary health care at local government level. There is however, a clear need for consultation and coordination; at local, provincial and national government level.

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Increasing allocative, administrative and dynamic efficiency, as well as matching public expenditure levels to majority preferences provide a strong argument for the local authority to be the dominant player in primary health care. A decentralised system seems a realistic political possibility, administratively feasible and a desirable outcome and makes for a more effective delivery of primary health care services. From an efficiency and equity point of view the local authority is the most appropriate government agency to perform the primary health care function. Flexibility will be the main governing principle for the assignment of the tasks.

A decentralised arrangement is eminently achievable in the Metropolitan Area of Cape Town. The strength of the strategy has as its emphasis on a mechanism to

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achieve results on the ground. A decentralised approach will enable government to more equitbly and efficiently respond to articulated priorities and observed opportunities at the local level and will create appropriate outputs in the places where they are most needed. It is based on participatory decision-making at the local level. A decentralised system will lead to a viable, vigorous and delivery oriented primary health care service, structured according to the real needs of the citizens. The local government will articulate local interests, provide efficient and equitable service delivery and promote democratic accountability.

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Annexure 1

Type	Municipality	Total	Metropolitan total
Clinic	Blaauwberg Municipality	3	**95**
	City of Cape Town	34	
	City of Tygerberg	24	
	Helderberg Municipality	5	
	Helderberg Municpality	1	
	Oostenberg Municipality	13	
	PAWC	1	
	South Peninsula Municipality	14	
Community Health Centre	City of Tygerberg	1	**37**
	Community Health Services Organisation (PAWC)	31	
	PAWC	1	
	PAWC & City of Tygerberg	2	
	PAWC & South Peninsula Municipality	1	
	South Peninsula Municipality	1	
		1	
Community Health Centre (After Hours)	**Community Health Services Organisation (PAWC)**	**6**	**6**
Community Health Centre/Clinic	Community Health Services Organisation (PAWC)	2	**7**
	PAWC & City of Tygerberg	3	
	PAWC & Oostenberg Municipality	1	
	PAWC & South Peninsula Municipality	1	
Dental Clinic	**Community Health Services Organisation (PAWC)**	1	**1**
District Surgeon (full-time)	**City of Cape Town**	1	**1**
Midwife Obstetrics Unit	City of Cape Town	1	**12**
	Community Health Services Organisation (PAWC)	11	
Mobile Service	Blaauwberg Municipality	3	**8**
	City of Cape Town	1	
	City of Tygerberg	1	
	Helderberg Municipality	1	
	Oostenberg Municipality	1	
	South Peninsula Municipality	1	
Reproductive Health Service	City of Tygerberg	1	**6**
	Community Health Services Organisation (PAWC)	1	
	PAWC	2	
Reproductive Health Service	Oostenberg Municipality	1	
	PAWC	1	
Reproductive Health Service Points	Blaauwberg Municipality	1	**10**
	City of Cape Town	2	
	City of Tygerberg	1	
	PAWC	5	
	South Peninsula Municipality	1	
Satellite Clinic	Blaauwberg Municipality	5	**17**
	City of Cape Town	5	
	City of Tygerberg	1	
	Oostenberg Municipality	1	
	South Peninsula Municipality	5	
School Health Services Unit	**City of Cape Town**	**1**	
TOTAL COUNT OF METROPOLITAN AREA		**201**	

Source: Department of Health: Directorate: Information management - 16/02/01

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