The devolution of health services at Pixley Ka Seme District Municipality in Northern Cape Province, South Africa

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Abstract

This policy and practice note analyses the provision and implementation of municipal health services since decentralisation in South Africa, through a case study of Pixley Ka Seme District Municipality in Northern Cape Province. The purpose of the study was to determine whether municipalities are able to render the services they are tasked with since decentralisation was implemented. The findings are broadly positive, although concerns remain about the adequacy of both funding and enforcement powers to discharge the municipality's environmental health mandate. The paper concludes that all spheres of government should collaborate – and also engage with other stakeholders such as the private sector, community-based organisations, community members and political leadership – to ensure that the function is implemented in line with national regulations.

Keywords: Decentralisation, devolution, environmental health services, 'equitable share' formula, municipal health services, Northern Cape Province, service delivery, South Africa

Introduction

A wide range of public services have been decentralised in South Africa since independence in 1994 – including, from 2008, local environmental health services (EHSs). These include functions such as water monitoring; food quality control; waste management; health surveillance of premises;

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surveillance and prevention of communicable diseases, including vector control; monitoring of environmental pollution; and disposal of dead bodies.

EHS provision is a subset of municipal health services (MHSs), as per Section 32 of South Africa's National Health Act 61 of 2003. The foundational legislation is the Municipal Structures Act 117 of 1998 (Republic of South Africa 1998). Additionally, the MHS function is governed by South Africa's National Environmental Health Norms and Standards, which regulate the functioning of the service, monitor the work of environmental health practitioners (EHPs) and oversee the implementation of regulations.

MHS is funded through a mix of municipal revenue and the central government 'equitable share' allocation. Municipalities are required to allocate one EHP per 10,000 citizens. Environmental health services were decentralised to district municipalities (Category C) and metropolitan municipalities (Category A) from Provincial Departments of Health and local municipalities (Category B) in line with the Municipal Structures Act (Act 117 of 1998) in South Africa. This was due to legislative changes after the 1994 elections in South Africa, which had a bearing on the provision of environmental health services. Municipalities were given authority to provide municipal health services. This process was derived from the Constitution of the Republic of South Africa of 1996.

The decentralisation of the service was meant to improve the access to environmental health services in all areas. The district municipalities are mandated to provide MHSs to communities within their respective municipal areas, to ensure that quality and equitable service is offered to all living in the country, irrespective of race, gender, financial status and the area in which one lives. Under decentralisation, MHSs were fully transferred from provincial governments to local municipalities – including their challenges, resources, assets and power. The rationale was that it is easier for local people to hold service providers accountable if services are managed and delivered locally.

District municipalities are expected to provide MHSs as per Section 32 of the National Health Act 61 of 2003. In the health context, decentralisation refers to the devolution of powers, administration and fiscal functions to local government for the provision of health services. Ideally, the decentralisation process should ensure that resources are adequately distributed to enable the equitable provision of MHSs and respond to any health challenges within the local government sphere (Zon et al. 2017, p. 1328). Further, Zon et al. (2017, p. 1332) add that the allocation of resources for effective provision of MHSs in district municipalities is associated with decentralisation; the management of finances and equal distribution; involvement of the community being serviced and the availability of resources from donors and responsible community.

However, district municipalities have faced numerous challenges that affect the quality of services and hinder their capacity to offer these services equally to all citizens (Singh and Bernet 2014). Various

causes have been proposed. For example, Penno et al. (2013, p. 2) and Smith (2008) found that municipalities use differing economic and non-economic factors in their decision-making, which can cause disparities. Additionally, Penno et al. (2013, p. 2) argue that MHSs have to share resources with other priorities of the municipalities, which can lead to uneven allocations. One EHP is allocated per 10,000 households (1:10,000) in order to provide MHSs. However, significant similarity factors are used to allocate resources, even though there is substantial distinction in the interpretation and application of these factors, as the provision has been decentralised. Most formula for funding systems are intended to help allocate economic and non-economic resources, ensuring that MHSs are offered equally to all citizens to assist district municipalities in implementing the provision effectively and efficiently. For health services to be offered equitably in different municipalities, a differentiated approach is required, as the rural and urban municipalities vary, and municipalities need to manage public finances and implement MHSs through their capital budget, with limited resources and capacity, as district municipalities do not generate revenue and MHS provision was decentralised from local municipalities and provincial government. In this context, Liwanag and Wyss (2019) suggest that local government decision-makers should be capacitated on what they are accountable for in terms of the provision of MHSs' decentralised function. This would allow for allocation of resources, more capacity and understanding of different functions of MHS and the challenges in implementing the service since decentralisation. This paper examines these challenges in more detail, and offers some recommendations for improving service delivery. The purpose of the paper is to analyse the performance of the municipal health services function since the implementation of decentralisation in the Pixley Ka Seme District Municipality (PKSDM).

Statement of methods

The study employed a qualitative research methodology using primary and secondary data collection techniques. It used a case-study approach to analyse the provision of MHSs in PKSDM of the Northern Cape Province, South Africa. The province comprises of five district municipalities that are currently authorised to provide MHS, namely: Frances Baard District, John Taolo Gaetsewe District, Namakwa District, Pixley Ka Seme District, and ZF Mgcawu District. PKSDM covers a very large area with a very dispersed population, leading to specific challenges in service delivery. Primary data was collected from PKSDM officials and secondary data was drawn from government documents in the public domain, particularly those focusing on decentralisation and provision of MHS in local government.

The study was conducted from May 2022 to January 2023. Primary data was collected through face-to-face interviews using a semi-structured questionnaire (carried out online using Microsoft Teams) with six municipal officials: three executive managers, one middle manager, one manager and one EHP. The list of interviewees was approved by the municipal manager and we applied for ethical clearance which was approved. A non-probability sampling was used. PKSDM was selected and sampled because of

its performance in the provision of MHSs and it has developed policies and by-laws that have played a critical role in its provision. Interviews with participants took approximately 45 minutes to be completed and collected data was analysed using the inductive method. Secondary data was collected from a literature review of the following sources: municipal integrated development plans (IDPs); Auditor General reports; municipal annual reports; a capacity assessment report commissioned by the South African Local Government Association (SALGA); the Northern Cape MHS Summit Outcomes Report; and the Outcomes Report of the SALGA Environmental Health Indaba 2021. Consulted sources ranged from available literature published between 2000 to 2023.

International and national context

Decentralised governance of healthcare has been widely adopted globally over the past three decades. A primary objective is to improve overall health system performance. This trend is usually traced to the 1980s and disappointment with the performance of central governments (Berkes 2010, p. 489), and the expectation is that decentralisation will drive technical and allocative efficiencies, empower local governments, increase accountability, and improve the quality, cost and equity of healthcare services (Sumah et al. 2016, p. 1183). In some countries it has also been seen as a measure to improve community participation in the policy and planning process. However, Spina (2014, pp. 448–449) claims this process has often been impeded by the failure of central governments to provide avenues for effective citizen participation.

Regmi et al. (2010, pp. 371–372), using examples from Nepal, highlight that transferring full legal authority along with responsibility is essential for the success of decentralised health services. More recently Bwengye (2018, pp. 142, 145) argues that local governments in countries that have implemented decentralisation play a vital role in holding central governments to account to ensure that programmes are genuinely decentralised – ie with funding and authority in addition to responsibility – as well as effectively and efficiently implemented. This is achieved through setting up monitoring systems, building the capacity of local government, and engaging the community.

In the health context in South Africa, the allocation of resources for effective provision of MHSs in district municipalities is associated with factors such as decentralisation, the management of finances and their equal distribution, involvement of the community being serviced, and the availability of resources from donors and the community in question (Zon et al. 2017, p. 1332).

District municipalities may only delegate MHS responsibilities to local municipalities if there is a signed service level agreement in place between the district and the relevant local municipality.

Definition of environmental health services

In South Africa, environmental health is a function that was decentralised to district municipalities (Category C) and metropolitan municipalities (Category A) from Provincial Departments of Health and

local municipalities (Category B) in line with the Municipal Structures Act (Act 117 of 1998). Therefore, Nicolopoulou-Stamati et al. (2015) draw a distinction between MHSs and EHSs, stating that municipal health deals with the impact of the environment on human health – eg air or water pollution, or the contamination of soil or food – whereas environmental health addresses the health effects of natural hazards, together with challenges such as disease and health inequalities including incidences of selected communicable and non-communicable diseases which have an influence on the physical environment. Furthermore, the MHS function within municipalities is guided by the National Environmental Health Norms and Standards, which regulate the functioning of the service for different environmental encounters within premises and ensure acceptable monitoring standards for EHPs and the implementation of regulations. The MHS function is funded through municipal revenue and equitable share allocation. The crucial consideration is whether decentralisation of the function has improved the provision of the service to communities as the service should be provided at the grassroots level. They list the main environmental health responsibilities as ensuring the following areas are handled in line with government regulations:

- Water: water quality, safety and availability – including drinking water; wastewater treatment processes.
- Food: safety and hygiene in food production (manufacture, handling and quality); inspections of premises where food is consumed, manufactured, distributed or stored.
- Waste: refuse collection, storage and disposal; management and disposal of other types of waste (eg health waste, sewerage).
- Health surveillance of premises: assessments for environmental health impact, structural safety, indoor air quality and ventilation.
- Communicable diseases: prevention and containment; awareness programmes; hygiene promotion.
- Vector control: removal of any rodents, insects and pests that could affect public health.
- Environmental pollution: identification of any agents or instances of environmental pollution; enforcing environmental laws; holding polluters accountable.
- Disposal of the dead: regulating and supervising undertakers, graveyards and cemeteries; managing burials, body disposals and exhumations.

Devolution as a driver of differentiation in municipal health services

Different municipalities in South Africa have different understandings of MHS mandates, and over time this has led to differentiated approaches in implementing the service. This is not necessarily a problem, however, as (in line with decentralisation theory) it can be seen as a sign that functions are closely tailored to communities' needs, which may result in varying priorities and governance structures.

However, there should always be accountability for programmes, projects and functions within the local sphere of government. The MHS function should be integrated into the municipal IDP, and allow community members to play a part in ensuring that the function is implemented.

Findings

Phase 1: secondary data (survey of literature)

The literature review consulted the following documents, with key findings summarised below:

PKSDM Annual Report 2019/20 This report found that the provision of MHSs in PKSDM had improved since decentralisation. The municipality is committed to ensuring that the function is implemented effectively and efficiently (PKSDM 2020a, p. 4), and has integrated MHSs into its IDP. It uses key performance indicators (KPIs) and annual targets to measure progress, and has an annual Service Delivery Budget Implementation Plan (SDBIP) (PKSDM 2020b, p. 34). The role and function of its environmental health services are separately outlined. However, the report also highlights various challenges:

- EHPs are currently unable to enforce the MHS by-laws fully, as they are not law enforcement officers.
- EHPs are not currently accredited environmental inspectors, meaning they lack powers to implement South Africa's National Environmental Health Norms and Standards.
- There is a serious shortage of both office administrators and EHPs, and PKSDM is unable to meet the statutory ratio of one EHP for every 10,000 citizens.
- Data capture (both field and personnel statistics) is currently inefficient in both time and financial resources, as it relies on a manual system.

PKSDM Integrated Development Plan 2020/21 (aligned to environmental health actual performance). The PKSDM planning process outlines the powers and functions of the municipality, its roles and responsibilities internally and externally, and public participation in the IDP process. The integration of MHSs into the IDP by the municipality indicates the ownership of the function by the municipality, as planning and budgeting for this provision is vital.

The IDP report of 2020/21 indicated that municipal integration of MHS into the IDP, and the allocation of annual targets, are delivering an effective and efficient service, despite delays in the introduction of a planned electronic data reporting system (PKSDM 2020b, pp. 103–105). The MHS function has an important place within the district municipality, and recognises the need for continuous learning and knowledge sharing between EHPs, business, the public sector and the community. The municipality has improved its health and hygiene training and campaigning, and the MHS function has become a vital conduit to increase community knowledge and activation on health and hygiene issues.

SALGA Municipal Health Services booklet 2019 SALGA developed an MHS booklet that guides municipalities in the provision and implementation of the MHS function in 2019. The booklet provides different legislation, scope of practice for environmental health, the role players in the delivery of MHS, human resources for MHS, funding of the function, training and development for EHPs, municipal norms and standards audit, governance structures for MHS, IGR structures, the roles of municipal senior managers and councillors and the implications of non-delivery of MHS in the municipalities (SALGA 2019, pp. 5–20). The booklet indicates what is required from the district municipalities to ensure the successful provision of MHSs, and the need to allocate the municipal administrative funds to subsidise the equitable share. The district municipalities do not collect revenue, as the local municipalities collect the revenue for basic services rendered to communities. The booklet does not guide the municipalities on how to generate revenue through MHS, as the district municipalities are rendering a service to different stakeholders and communities at large. The booklet indicates the roles and responsibilities of the municipality, but not the responsibilities of communities where accountability is required to be taken by communities where they infringe the MHS by-laws.

Auditor General Report to Northern Cape legislature and the PKSDM Council 2020 The assessment of the performance of municipalities is undertaken yearly by the Auditor General (AG) to ensure compliance by the municipalities and accountability for the plans, budgets, expenditure and performance for the financial year. Municipalities submit monthly financial statements and progress reports to the AG, where their performance is measured according to criteria set by legislation and the AG. The PKSDM final opinion of the AG Report for the 2019/20 financial year states that *"the financial performance and cash flows met the standards set by the legislation governing the standards of accounting practices (DORA) and the MFMA"* (AG Report 2020, p. 1) which indicates that the financial position of the PKSDM has met all of the standards. However, in the analysis of the report it was indicated that the municipality underspent on their budget compared to actual performance due to COVID-19 decreasing expenditure, which indicates that proper planning and allocation of funding is required. During the pandemic the MHS played a vital role, as essential services and more resources were required and unspent budget may have been redirected to EH services to address the challenges indicated by the municipality and meet the 1:10,000 ratio (AG Report 2020, p. 2).

SALGA – municipalities' status reports 2014 to 2022 Since 2014 SALGA, together with the South African Institute of Environmental Health, has reported on the status of municipalities' implementation of the MHS function. Data available for PKSDM revealed that the municipality has had a challenge in terms of staff retention. Due to financial constraints, PKSDM can only appoint one EHP per financial year (PKSDM 2022), even though a number of EHPs have resigned and need to be replaced. The status reports also regularly highlight a range of challenges in the implementation of the function:

- Budget allocation for MHSs: the budget allocation for the MHS function in PKSDM is a mix of 'equitable share' funding from central government and municipal tariffs and fines, which

generate revenue from services provided. However, the funds are not ring-fenced for MHS, but are part of the municipal capital budget, and therefore risk being redirected to other services in the municipality.

- Limited administrative capacity, and shortfalls in the appointment and retention of EHPs.
- Inability of EHPs to enforce municipal by-laws, as their roles are not at a sufficiently high grade.

Nevertheless, the report indicates that there is support from the municipal council and management to prioritise the provision and implementation of the MHS function.

National MHS Assessment Report on Municipal Health Services Capacity 2021 This report noted that PKSDM had completed the devolution process for MHSs, and was providing the function in all of its eight local municipalities. It also noted, however, that the designation and appointment of EHPs could be problematic, as they work across many different areas (eg health, air quality, environment, waste management) and hence their responsibilities can be cross-functional – but individuals may lack the training or certification to be fully empowered in their role. This was one reason why MHS allocations were not ring-fenced (SALGA MHS Capacity Report, 2021, p. 34). Another issue identified was that the MHS unit budget is stretched by the huge size of the district, and the scattered nature of households which makes it more difficult for EHPs to cover their statutory 'patch' of 10,000 citizens.

Phase 2: primary data (interviews)

This phase consisted of interviews with PKSDM employees, conducted remotely. Questions were arranged into three main areas, and responses are summarised below.

Does the municipality implement the MHS function in line with South Africa's National Environmental Health Norms and Standards?

The consensus from participants was that the municipality makes considerable efforts to do so, but was hampered by having only eight EHPs – when it actually needs 17 to cover the entire PKSDM area. There was also at the time of interview no MHS manager in post. Due to these staff shortages, the municipality cannot meet the statutory 1:10 000 ratio for numbers of EHPs. There was concern that the shortfall could cause health impacts in the community.

However, it was also noted that, even with this shortage of capacity, the municipality achieved 90% ratings in its audit, placing PKSDM in the top ten municipalities in the country. Some respondents commented that the staff shortages were allowing junior EHPs to develop their skills, by taking on tasks normally carried out by more senior staff; but there was also a view that the high performance may be a cause of staff turnover, if the existing EHPs feel overworked.

How can municipal policies and by-laws be amended to improve municipal health services?

Respondents indicated that the PKSDM by-laws are functional, and the incorporation of MHSs in the municipal IDP and SDBIP anchors the status and budget of the function. The use of KPIs, and the setting of annual and quarterly targets, also help the function to perform well. It was noted that communities were positive about the provision and implementation of MHSs in their areas. Targets set at the local municipality level – which are very specific to a particular area – were felt to be working well.

However, EHPs are hampered in their work by the fact that they are often not officially appointed 'peace officers'.[1] Many EHPs are unable to enforce by-laws and issue fines directly, but rather depend on the South African Police Service (SAPS). In some instances, this leads to EHPs losing cases because SAPS lacks capacity to investigate environmental health offences – for example, by seizing products. PKSDM is attempting to mitigate this problem by reviewing its by-laws annually to ensure that they comply with any regulation changes.

Respondents also suggested that it would be better if the MHS function had its own executive manager, who would be an EHS specialist reporting directly to the municipal manager – rather than being line-managed by the corporate services function, as currently. But there was general agreement that corporate services have nevertheless supported the function to improve the delivery of services.

It was also noted that there is a practical need for the district to work with local municipalities for the implementation of the MHS function to be fully successful – but that this practical reality is not well covered by the existing legislation.

Are budget allocations adequate?

Participants emphasised the importance of comprehensive and up-to-date MHS policies and by-laws to endorse PKSDM's enforcement work and imposition of tariffs and fines. These policies and by-laws underpin the municipality's ability to generate revenue. However, respondents expressed concern that the revenue collected goes into the municipality's capital budget rather than being ring-fenced for the MHS function. They were happy for the generated revenue to contribute to the enhancement of other functions within PKSDM, but noted that MHS requires more funds of its own to develop its capacity. It needs more staff and adequate resources to ease the workload of EHPs, which would in turn lead to more comprehensive, effective and efficient MHS service provision.

[1] Peace officers are law enforcement officials who maintain public order and safety. Their powers include enforcing laws and ordinances, conducting patrols and preventing crime.

Discussion and recommendations

It is clear from the above findings that since devolution much progress has been made within PKSDM in its MHS provision, and resources have been fruitfully invested – but challenges do persist. This section provides some recommendations for improving the implementation of the function.

Funding allocation: The municipality's budget allocation appears insufficient to implement a staffing level of 1 EHP to 10,000 citizens, and hence to comply with Department of Health (DoH) requirements. The authors believe there is a need to review the 'equitable share' formula used to allocate funding from central government. The whole of Northern Cape Province requires a differentiated approach from the rest of the country, as it covers a vast area with widely dispersed households.

The DoH should intervene to protect the independence of municipalities' MHS functions by transferring sufficient resources – while continuing to hold all municipalities accountable for the manner in which the function is implemented. Additionally, the authors recommend ring-fencing the budget allocated to the MHS function, to allow full implementation of its remit.

Relations with local municipalities: it was noted that local municipalities – smaller units than districts – in practice carry out some MHS functions, but have no allocated budget for this. In some cases, their work also generates revenue. The authors recommend that district and local municipalities sign agreements to ensure that the assignment of EHPs to specific local municipalities is supported, and the local municipalities provide their local EHP with both office space and protection against potential pressure from communities and political heads.

EHP powers and capacities: There is currently a gap between EHPs' responsibilities and the legal powers vested in them. This hampers the provision and implementation of the MHS function. The authors recommend that EHPs be given accreditation as both peace officers and environment inspectors, and also be given a higher municipal grading to allow them to enforce PKSDM by-laws.

A first step would be closer cross-department collaboration within the municipality: for example, more engagement with the department that accredits environmental management inspectors. PKSDM also needs to allocate a training budget for EHPs to ensure their continuous professional development, which will allow them to maintain their professional registration. One source of funds to investigate would be bursaries from the Local Government Standard of Education and Training Authority.

Field reporting systems: The municipality still captures data from site inspections manually, which slows down service delivery and drains financial resources. The authors recommend establishing an internet-enabled data capture system using mobile devices, for use by EHPs on sites and in the field, with input instantly and automatically uploaded to the municipal database. Such a system would enable EHPs to issue both fines and certificates without returning to the office.

Recruitment and selection: For many years, PKSDM has had to cope with limited staff and resources, including high staff turnover. The authors recommend broadening recruitment approaches: for example, working with schools to promote environmental health as a rewarding career, highlighting the importance of the EHP role when advertising vacant posts, or experimenting with different incentive packages for new recruits. They also recommend creating a specific EHP retention policy, which would include career development and an upward mobility plan.

Community awareness and participatory structures: The municipality already runs campaigns on health and hygiene, but not enough business owners are aware that they will be held accountable if infringement of the law takes place on their business premises. The municipality needs to allocate a budget for such campaigns to ensure the safety of the community. The authors also recommend that PKSDM create an MHS district forum, bringing together sector departments, businesses and civil society. The forum could, for example, initiate preventive health campaigns which if successful would reduce healthcare costs and demand for social assistance.

IDP targets: The municipality sets performance targets for MHSs in its five-year strategic IDP. However, these targets are not usually realistic; for example, they include water sampling targets, but PKSDM has no capacity to carry out such work. By contrast, EHPs also have annual operational plans in which they set targets according to the needs of individual local municipalities – and these targets are much more likely to be met. The authors recommend that PKSDM aligns its IDP and the annual plans to ensure that all targets are realistic, and that sufficient budget is allocated to the plan as per the IDP.

Organogram: Currently the MHS function at PKSDM is led by a non-specialist, the corporate services manager. The authors recommend that the municipality instead appoints an executive manager who is an EHS specialist, who would report directly to the municipal manager and the executive mayor.

Conclusion

The formal decentralisation of South Africa's MHS provision took place in 2008, and since then local municipalities have recorded mixed results. In the case of PKSDM, the authors found that decentralisation had brought growth and improvement in the function, although much still needs to be done. The authors conclude that placing the MHS function at district municipality level is the correct approach, albeit proper support and management of allocated resources are essential. In order to maximise resources, the authors recommend research into ways to increase revenue generation by the MHS function, and also into a more nuanced, differentiated approach in the allocation of the central government's 'equitable share' formula.

Finally, the authors recommend research into how district municipalities could work more closely with local municipalities, an approach which would iron out inconsistencies and generate revenue for both

parties, in turn leading to a better service for communities. This would be the best way to bring services closest to the people and would also play an important role in implementing one of the government's key priorities: the national campaign of 'prevention is better than cure'.

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