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**Reinterpreting the implementation gap: a case based analysis of District Health  
System implementation in the Western Cape Province in South Africa**

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## **Abstract**

This dissertation examined an implementation gap through a case study on implementing a District Health System (DHS) in the Western Cape Province of South Africa between October 2001 and April 2006. The research project explored why this implementation gap existed and what could be learnt about public policy implementation from studying this implementation gap. The main data collection methods included interviews, public and other documents and observations on the public health system in the Western Cape Province.

I argue that implementation gaps could be interpreted as a signal of policy change instead of implementation failure. The key finding is that the Provincial Government of the Western Cape shifted its intentions regarding DHS implementation. The initial intention was to decentralise primary health care services to a metropolitan municipality. The decision, which was actively implemented, however centralised these services within the provincial government and started the process of the provincialisation of personal primary health care services in the Western Cape Province.

This dissertation contributes to public policy implementation and public policy process literatures. It demonstrates why policy change is an alternative interpretation of implementation gaps to implementation failure and how policy change occurs during implementation. Policy change and public policy implementation are commonly two separate research themes within Public Policy Studies. The persuasion framework developed through this research project is an analytical tool that may be applied in research on implementation processes to examine whether an implementation gap is

signalling policy change. The central theoretical elements in this framework that link policy change and implementation processes are the interactive effects of ideas and interests and the role of argument as a persuading factor that leads to policy change. The dissertation emphasises the role of language in public policy processes and argument and persuasion were deemed important elements in public policy processes.

## **Acronyms**

ANC: African National Congress

ACF: Advocacy Coalition Framework

BMTT: Bi-Ministerial Task Team

CEO: Chief Executive Officer

CHC: Community Health Centre

CHSO: Community Health Services Organisation

COCT: City of Cape Town

COJ: City of Johannesburg

CWDM: Cape Winelands District Municipality

DHS: District Health Services

DFID: UK Department for International Development

DOTS: Directly Observed Treatment

DOTS: Directly Observed Treatment Short Course

DEX: District Executive

DP: Democratic Party

EDA: Economic Development Agency

EMS: Emergency Medical Services

EHS: Environmental Health services

GDH: Gauteng Department of Health

GNU: Government of National Unity

HIV: Human Immuno-deficiency Virus

IDMT: Integrated District Management Team

IMCI: Integrated Management of Childhood Illness

IMATU: Independent Municipal Association of Trade Unions

IR: International Relations

IRC: Institutional Rational Choice

MDHS: Metropole District Health Services

MFMA: Municipal Finance Management Act

MINMEC: National Minister and Nine Provincial Members of the Executive  
Committees

MEC: Members of the Executive Council

MOU: Maternity and Obstetrics Unit

MDEMC: Metropole District Executive Management Committee

NP: National Party

NNP: New National Party

NHC: National Health Council

ODA: Organisation for Africa Development

PGWC: Provincial Government of the Western Cape

PPHC: Personal Primary Health Care Services

PHC: Primary Health Care

PHCA: Primary Health Care Approach

PAWC: Provincial Administration of the Western Cape

RSA: Republic of South Africa

RDP: Reconstruction and Development Programme

SAMWU: South African Medical Workers Union

SALGA: South African Local Government Association

SC: Moe's Structural Choice

SLA: Service Level Agreement

TB: Tuberculosis

UN: United Nations

UWC: University of the Western Cape

UCT: University of Cape Town

WECLOGO: Western Cape Local Government Organisation

WCDoH: Western Cape Department of Health

WHO: World Health Organisation

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## **Chapter 1: The implementation gap in health system reform in the Western Cape Province**

### **1.1 Introduction**

The post-apartheid South African government adopted a Primary Health Care Approach (PHC) and a District Health System (DHS) as mechanisms to transform a highly fragmented and racially biased health system into one that works in the interests of all South Africans since 1994. The broad practical question which this research addresses is how has health system reform been implemented in South Africa? In particular, this research has examined the implementation of a District Health System in the Western Cape Province, one of the nine provinces (geo-political regions) in South Africa.

During my initial literature search for the DPhil research outline I identified an implementation gap related to District Health System development in the Western Cape Province. The Provincial Government of the Western Cape (PGWC) Cabinet had taken a decision in 2001 that would have decentralised the delivery and management of primary health care services by transferring the responsibility for these services from the provincial government to the metropolitan municipality (CHSO, 2003: 7; Health Services Task Team, 2002: 1). However, this decision was not implemented (CHSO, 2003: 8).

An implementation gap thus emerged because the PGWC Cabinet policy decision was not converted into practice. This implementation gap was important because it meant that the provincial government was not acting to implement an important national

health policy goal. The PGWC decision to transfer primary health care services to the City of Cape Town municipality would have been a first step toward creating a municipality-run DHS in the Western Cape Province. The intention of the national health policy was to create a decentralised health system where municipalities are responsible for primary health care services within health districts. This state of affairs could be interpreted as indicating implementation failure.

This chapter describes the context for health system reform in South Africa. In the first section of this chapter I contrast the nature of the pre-1994 health system with the health system expectations of the post-1994 South African government. I address two main questions: what were key features of the health system during the apartheid era and what was the post-apartheid policy vision for health system transformation? I highlight why the health system in South Africa required transformation, the vision for transforming the health system in a post-apartheid South Africa, and the difficulties associated with implementing district health systems. In the second section I identify the research question and the theoretical insights that I explored in this dissertation. In section three I briefly outline the research design and methods used during fieldwork. I conclude by describing the main focus of each chapter in the rest of this dissertation.

## **1.2 The need for, and the direction of, health system transformation in South Africa**

This section addresses two questions: what about the health system needed to change, and what was the vision for health system reform? In the first discussion on the health system during the apartheid period I highlight how race-based discrimination in health service provision became an established practice through the structuring of the

government in South Africa. The second discussion draws attention to the dramatic changes that the first post-apartheid government envisioned for transforming the health system in South Africa. These contrasting pictures sketch the framework within which DHS implementation within the Western Cape Province may be understood. Furthermore, this contrasting picture highlights what needs to change when transforming the health system in South Africa. The challenge lies in reconstituting established relationships and challenging established ideas about how the South African health system should function.

#### *The health system during apartheid*

Racism was not a new phenomenon in post-1948 South Africa as it was also a feature of the colonial administration within the South African territory. This means that health services provision was always skewed toward privileging white people. When the National Party (NP) came to power in South Africa in 1948 the era of systematic apartheid began. Apartheid, when understood as a worldview, centred on the belief that the different racial groups in South Africa should live and develop separately.<sup>1</sup>

Successive National Party governments from 1948 onward realised this belief through government policies and laws and through the organisation of state institutions. For example, racism was institutionalised through legislation that prohibited interracial mixing and imposed separate living areas for different racial groupings in South

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<sup>1</sup> The racial groups were social constructions. A particular example of how this categorisation still affects how people refer to themselves in South Africa is the construction of persons of mixed descent who were classified as 'coloureds'. This racial construction has been adopted as an identity and it has become the basis for people of this group to distinguish themselves from other groups.

Africa.<sup>2</sup> Kotzé (1989) demonstrates how the government system in the 1980s and the state machinery was organised to defend and maintain the apartheid system.

Savage (in Van Rensburg, 2004: 79) notes that the structure of apartheid was embedded within the health system. This meant that access to, and the quality of, the services that people received were based on the racial hierarchy which the government at the time implemented. Researchers who explored the nature of the health system during the apartheid period emphasise that the homelands policy and the establishment of the tricameral parliament were key policy decisions that affected the nature of the health system. One of the key effects of these policy decisions was that they produced a fragmented health system. For example, Van Rensburg (2004: 79) notes that the ideology of separate development took root in the health system when the homelands policy was passed. He describes the fragmentation as follows:

Structurally and administratively, the policy added ten additional state departments of health at the first tier of government; health care in South Africa became geographically much fragmented as ten separate political units, each having jurisdiction over health in its own area, came into existence... The homelands... [were] examples of further racial fragmentation of South African health care... each homeland was, after all, created for a specific black ethnic group; lastly fragmentation also filtered through the structure of the health professions (Van Rensburg, 2004: 84).

Fragmentation here refers to how the apartheid government created a number of health systems because it sought to geographically confine black ethnic groups in South Africa in separate, 'independent' areas within the boundaries of South Africa. For

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<sup>2</sup> Goldstein and Keohane (1993: 20) note that "Once ideas have influenced organizational design, their influence will be reflected in the incentives of those in the organization and those whose interests are served by it." Furthermore the institutionalisation of ideas means that even when ideas are unpopular, they will still have an effect (Goldstein and Keohane, 1993: 20). The ideas that informed apartheid were institutionalised through laws such as the Prohibition of Mixed Marriages Act, Act 55 of 1949 and the Group Areas Act, Act 41 of 1950.

example, the Transkei was an area in the eastern part of South Africa which was designated for Xhosa people. The NP government promoted self-rule in the area through homeland governments, and part of self-rule dictated that Xhosa people in the Transkei had to manage their own health affairs. Van Rensburg (2004: 85) notes that mission hospitals were nationalised and given over to homeland governments. Missionary societies created missionary hospitals in mainly in black rural areas and they provided health services to black people (Van Rensburg, 2004: 62). These hospitals were then well placed to become the health facilities for the homelands.

Parliamentary representation through the tricameral or three-chamber parliament meant little in terms of ensuring equal health benefits for all race groups, because only three groups had representation in South Africa. The tricameral parliament comprised three legislative houses, which respectively represented whites, coloureds and Indians. In the health system different racial groupings each had its own health department (Van Rensburg, 2004: 79). Even though these groups had representation and their own health departments, this did not mean that the quality of the health services provided were the same. Doherty *et al.* (1996: 68) note that racial planning was reflected in the nature of health facilities with regard to their distribution, physical state and functional design. Furthermore, “health care was allocated not in terms of need, but in terms of access to power” (Van Rensburg, 2004: 79). Therefore groups that were higher up in the racial hierarchy, meaning those closest to power, would have secured better access to, and enjoy higher quality, health services than those who were further down in the hierarchy. Black people were the lowest on the hierarchy and this is apparent in the fact that there was no representation for black people in the tricameral parliament.

Fragmentation was further evident in health systems because the various levels of government had health functions, but mostly health matters were the preserve of the provincial department (Power and Robbins, 1996: 35).<sup>3</sup> Van Rensburg (2004: 69) notes that health system fragmentation, particularly regarding the health functions of the respective levels of government, predates the apartheid era. He explains that the fragmentation of functions was implemented when the South Africa Act came into effect in 1909, creating the Union of South Africa, and “the four provincial administrations autonomously continued to provide public curative health services, environmental and preventative health services were still provided by local authorities” (Van Rensburg, 2004: 69). According to Van Rensburg (2004: 69), the South Africa Act of 1909 only confirmed that provincial governments had control over hospitals.

Inequality was also a feature of the health system during the apartheid period. A public health system in which racism was institutionalised meant that the quality of health services provided to people as well as access to health care by the racial groupings in South Africa differed (Van Rensburg and Harrison, 1995). The apartheid government system and the country’s laws were formulated to limit the access of mainly black South Africans to quality health services. For example, curative health services were provided in hospitals, which were mainly in large urban areas where mainly white people lived and black peoples’ access to urban areas was regulated. As a result black people in particular were excluded from well-resourced health care facilities (Kelly, 1990: 20).

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<sup>3</sup> McCoy (2000: 109) notes that at one point during the apartheid era in South Africa there were fourteen health departments. Provinces were responsible for managing hospitals, local municipalities were managing primary health care services and Regional Services Councils managed the mobile services that were provided to the rural populations.

The emphasis on curative health services was another important feature of the health system. Van Rensburg (2004: 75) describes the focus of health services as follows: “An inordinate emphasis on cure, curative services and institutional care prevailed, with not enough focus on either the prevention of disease or community-based care.” Health care funding, which came from the national government, promoted the dominance of curative health services relative to preventative and promotive health services. According to Kelly (1990: 21), the often stated cause of racial inequalities in health care was that the government focused spending on hospital-based care with limited funding going to primary health care. The emphasis was thus on cure rather than prevention and health promotion. This emphasis meant that the majority of the people suffered because the health system was not organised to promote the development of, in particular, a healthy black population. The health system was thus another link in an integrated strategy to maintain separate development.

The health system’s emphasis on curative health services made provincial governments beneficiaries of significant amounts of funding from the national government. McIntyre and Doherty (2004) reviewed health care financing in South Africa in a comprehensive text edited by Van Rensburg entitled “Health and Health Care in South Africa”. They point out that prior to the 1994 election a health expenditure review was conducted, which noted that “a high proportion of resources was devoted to curative, hospital based care that was situated mainly in urban areas” (McIntyre and Doherty, 2004: 378). Furthermore, they cite McIntyre *et al.* (1995), who pointed out that “In 1992/93 81% of total recurrent public sector health care expenditure was devoted to hospitals (both acute and chronic)” (McIntyre and Doherty, 2004: 378). Curative health services were provided in day hospitals and hospitals, which were the provincial administrations’

responsibility. The health system had retained the focus on curative care up until the early 1990s, when there were calls for change. It is therefore important to note that provincial governments have been significant actors in the public health sector and beneficiaries of national government resources for some time.<sup>4</sup>

During the apartheid era the government initiated research on how to improve the health system. Some health system reform recommendations included *extending* provincial governments' role in the public health system. The Browne Commission of Inquiry into Health Services (1986) was responsible for reviewing the health system for rationalisation (Van Rensburg, 2004: 90). One of its recommendations was that regional authorities should be given more scope so that they could tailor health services to community needs (Van Rensburg, 2004: 91). The Browne Commission also recommended that the minister of the National Health and Population Department would act as the central management agency and be responsible for health services policy (Van Rensburg, 2004: 91).<sup>5</sup> Van Rensburg and Harrison (1995) note that provincial governments consolidated their position over health services in the period after the 1986 National Health Plan. The provinces' autonomy was extended because they obtained a greater share of resources when executive authority for hospitals was devolved to their authority (Van Rensburg and Harrison, 1995).

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<sup>4</sup> Van Rensburg (2004: 69) indicates that the provincial authorities gained autonomous control over health matters as part of South Africa's unification processes from 1910 onward.

<sup>5</sup> In 1986 the Browne Commission recommended what the African National Congress has been pursuing as part of its health system transformation in post-1994 South Africa. Van Rensburg (2004: 91) notes that the Commission recommended decentralisation to regional authorities such as provinces and homelands in order to create a link between community needs and the health services that were offered. Furthermore, the Commission recommended that more resources be spent on primary health care and building community health services (Van Rensburg, 2004: 91). These are all aspects of a district-based Primary Health Care system (PHC), which refers to the combined system of the Primary Health Care and a District Health System (Van Rensburg, 2004: 412). The latter is in line with the Alma Ata Declaration of 1978. It would appear that the Commission's recommendations were based on prominent ideas in the international arena where the aim was to improve healthcare for all people.

Even from the early 1990s onward, when South Africa's transition to a more fair system of government was beginning, the focus of the health system did not change. Van Rensburg and Harrison (1995) note that from 1990 to 1994 a characteristic of this time were calls for changes to the health care system, particularly from those who sought a progressive health care system. This envisioned system would defragment and de-racialise the health system and government structures. The problematic factor at the time was that steps toward reform were taking place in an undemocratic context and were described as cosmetic rather than being the fundamental changes that were called for (Van Rensburg and Harrison, 1995).

Initiatives to reform the health system included the 1991 National Health Service Delivery Plan, which "incorporated the principles of accessibility, effectiveness, affordability, equity and acceptability in health care" (Van Rensburg and Harrison, 1995). It aimed to develop "co-ordinated and streamlined referral systems and systematic regional plans for health service development" (Van Rensburg and Harrison, 1995). Its implementation was problematic because of the reluctance of provinces to give up their control over primary health care and concerns about how much financial resources local authorities would expect in order to fulfil these responsibilities (Van Rensburg and Harrison, 1995). Thus reforming the health system prior to the democratic elections in 1994 was problematic, because of changing power dynamics between different governing authorities and the financial implications of decentralising primary health care services.

#### *Health policy expectations in post-apartheid South Africa*

The Government of National Unity (GNU) in South Africa selected the Primary Health

Care (PHC) Approach as the framework for health system reform when the Reconstruction and Development Programme (RDP) was adopted in 1994 (Owen 1995: 1).<sup>6</sup> The Primary Health Care approach is a global health policy initiative, a product of the World Health Organisation's (WHO) Alma Ata Declaration of 1978, which aimed to "protect and promote the health of all people of the world" (WHO, 1978). Primary health care is described as essential health care, and includes universal access and community participation at a cost which fits the community's and country's economic capabilities, as well as the socio-cultural and political context, and brings the health system closer to the people (WHO, 1978). The Alma Ata Declaration noted that national governments who adopted the PHC Approach were required to develop policies and strategic documents to implement primary health care through the coordination of sectors and the political will to mobilise and use the available resources (WHO, 1978).

The PHC approach, as it would be applied in South Africa, was defined in the Reconstruction and Development Programme, a policy document that the ANC adopted as its manifesto for the first democratic elections in South Africa in 1994. According to the RDP (ANC, 1994: 45), the PHC approach emphasises "community participation and empowerment, intersectoral collaboration and cost-effective care, as well as integrative care of preventative, promotive, curative and rehabilitation services." Integrating primary health care services in South Africa was a particularly important part of health system reform as these health services were fragmented because different

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<sup>6</sup> The Government of National Unity (GNU) was the name of the first democratically elected government in South Africa after the elections in 1994. The GNU comprised the ANC, the NP and the Inkhata Freedom Party (IFP). The GNU denoted a power-sharing arrangement between the major political parties in South Africa at the time.

levels of government were responsible for the complementary elements of primary health care services.

According to Owen (1995: 1), the GNU also committed itself to the District Health System, when it accepted the Reconstruction and Development Programme (RDP) in 1994. This was the management framework that would facilitate implementing a PHC Approach. In a 1995 National Department of Health consultation document on the DHS entitled “A policy for the development of the District Health System for South Africa”, Owen (1995: 6-7) provided the following description of a District Health System:

A District Health System based on Primary Health Care is more or less a self-contained segment of the National Health System. It comprises first and foremost a well-defined population, living within delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional. A District Health System therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self care and all health care workers and facilities, up to and including the hospital at the first referral level, and the appropriate laboratory, other diagnostic, and logistic support services.

There are therefore two important requirements when implementing a DHS. The first is establishing health district boundaries. Owen (1995: 2-7) notes a number of key features that the national District Health Systems Committee identified for health districts in South Africa. One of these features was that health district boundaries should not cross the boundaries of another administrative area, such as local government or magisterial districts, but that it should coincide with these boundaries but these boundaries need not be rigid (Owen, 1995: 7). In addition, every part of each province should be within a health district (Owen, 1995: 7), which means wall-to-wall

health districts in each province, and the size of the district should be based on local conditions.

Implementing a District Health System also required establishing a management team for each health district. Owen (1995: 2) describes the district level as “the level at which co-ordination of all district health services takes place, and is the unit of management of the health system that is best able to drive it.” The health district management team would be responsible for comprehensive primary health care services and “all essential care, including environmental health services, emergency services and first level hospital care” to be provided in a health district (Owen, 1995: 7). These services would be provided in a number of different facilities within the health district. A health district would have one or more of the following types of facilities: district hospitals, community health centres, clinics, smaller facilities such as mobile clinics and visiting posts (Owen, 1995: 7). According to this description, the health district management team is responsible for the public health service providers and the facilities in which these health services are offered.

Health system transformation through a district-based PHC approach was likely to be complicated. The national government expected that different health service providers in the country, with potentially conflicting interests, would cooperate to implement national health policy goals for transforming the health system. Creating a district health system throughout South Africa required that private health service providers and provincial and local government buy into the envisioned reforms.

What was perhaps not considered was the challenge presented by the health system reform vision to the power dynamics that existed within the health system. My research focuses on reform in the public health services sector. Many South Africans are dependent on the public health services. The public health sector reform aims to extend access to primary health care services, with nurses becoming the main health service providers instead of doctors. It also aims to decrease funding to public hospitals. This represents a complete reversal of the state of affairs in the public health sector as the focus starts to shift from curative health services provided in hospitals to integrated preventative, health promotion and curative health services in health facilities located within all communities in South Africa. The empirical chapters (Chapters 4 and 5) highlight some of the issues associated with implementing the PHC approach and a DHS in the Western Cape Province.

In summary, transforming the South African health sector meant changing a system characterised by institutionalised racism, fragmentation and a focus on curative health services into one that emphasised primary health care services: where a range of health services were integrated, and a district health system, as the health management approach, ensured that the needs of people in the respective health districts are met. Implementing this vision required a number of important developments: the creation of health districts, district health management structures, as well as the integration of a range of health services within these health districts. In the next section I discuss attempts to implement some of the latter requirements in the case of the Western Cape Province.

### **1.3 The research problem**

In 2001 the Provincial Government of the Western Cape Cabinet (PGWC) decided that primary health care services would be transferred to the City of Cape Town municipality (CHSO, 2003: 8). The decision represented a significant step toward integrating primary health care service delivery and management under one authority, which in this instance would be a metropolitan municipality. Furthermore, it indicated that the provincial government intended to decentralise responsibility for primary health care services. Integrating primary health care services and decentralising health services (Pillay, 2001: 764) were two important aspects of health system transformation (White Paper on the Transformation of the Health System, 1997).

The Community Health Services Organisation (CHSO) reported in its Annual Report 2002/2003 (CHSO, 2003: 8) that implementing the transfer was “stalled at the political level involving the Provincial Treasury, Provincial Health Department and the Cape Town Municipal Health Department.” The CHSO (2003) report does not indicate what the nature of the problem was. The report also identifies that the political environment, meaning leadership changes in the provincial and local government in the Western Cape, was an external factor that affected implementation (CHSO, 2003: 8).

I began this research with a public policy implementation lens. Therefore I viewed the lack of implementation as indicative of an implementation gap in the public health policy sector in the Western Cape Province. I treated this implementation gap, as many others had done before, as a theme worthy of examination. My core research question was thus: why was the PGWC Cabinet policy decision not implemented?

I was interested in the implementation gap because I interpreted the gap as a signal of implementation failure. According to Hill and Hupe (2009: 45), negative interpretations of implementation gaps stem from early research on implementation exemplified in the work of Pressman and Wildavsky (1984), whose notion of an “implementation deficit” influenced the way that researchers thought about implementation processes. They note that “This particular formulation has been seen as responsible for a pessimistic tone in much implementation literature, since it suggests that purposive action will be very difficult to achieve whenever there are multiple actors” (Hill and Hupe, 2009: 45). As first reported by Pressman and Wildavsky in the early 1970s, there is a long-standing relationship between implementation gaps and interpretations of these gaps as a sign of failure.

Initially my aim was to explain why implementation failed. Since the 1970s public policy implementation researchers had paid close attention to what produced implementation gaps. Cline, for example, notes that much public policy implementation research aimed “to analyse the problems of implementing policy” (Cline, 2000: 551). The focus on implementation gaps began with Pressman and Wildavsky’s (1984) attempt to understand why expectations of a federal employment policy for minorities were not realised in the United States. After nearly two decades of implementation research, Matland (1995: 146) concluded in his review of the implementation literature that implementation researchers identified over three hundred factors that affect implementation. Therefore, when beginning this research in 2004 I had over three hundred significant variables that could explain why the PGWC Cabinet decision to decentralise primary health care services was not implemented.

Furthermore, health policy researchers in South Africa offered potential answers that could be explored as factors affecting DHS implementation. These include organisational cultures that needed to change (Pillay, 2001: 752); the nature of the policy development process for the DHS; and the effects on intergovernmental relations (Mjekevu, 1996; Pillay 2001: 758). Other complicating factors include constitutional requirements (Pillay 2001); the lack of enabling legislation (Harrison-Migochi, 1998: 128; Forman *et al.*, 2003), issues between provincial and national government (Pillay, 2001: 759-760); decentralisation (Power and Robbins, 1996: 35; The Local Government and Health Consortium, 2004); the nature of health care funding (McIntyre and Gilson, 2000: 254; Thomas *et al.* 2004); issues of trust between provincial and local government (Pillay, 2001: 761); a lack of clarity on local government functions (Pillay, 2001); and unresolved issues related to governance (Harrison-Migochi, 1998: 128). Then at a provincial government level implementing health reforms face challenges because reform requires interdepartmental (Harrison-Migochi, 1998: 133) and intergovernmental cooperation. The CHSO (2003: 8) added another factor, as it suggested that conflict between the Provincial Treasury, Provincial Health Department and the Cape Town Municipal Health Department affected the transfer of primary health care services to the City of Cape Town municipality in the Western Cape Province.

As this thesis seeks to contribute to our understanding of public policy implementation processes, there seemed little value in only pursuing the factors that affected implementation in this particular case study. Instead I paid attention to how implementation gaps were interpreted. In the public policy implementation literature an implementation gap is often interpreted as signalling failure. One reason is that

implementation gaps are viewed as a problem that requires fixing. As Schofield (2004: 283) notes, a substantial amount of the knowledge that has been developed on implementation is based on the relationship between policy intentions and policy outcomes and “This knowledge has addressed the *congruity* between policy and outcome; where outcomes differs from the original policy intention it has been suggested that implementation has failed.” In Chapter 2 I discuss why implementation gaps are interpreted as signs of failure.

I developed a different research question based on insights from Mosse (2004, 2005) and Pretorius (2003). That question was: how else can one interpret implementation gaps? Mosse (2004, 2005) studied the relationship between development policy and implementation practices and concluded that mismatches between policy expectations and implementation practices are inevitable.<sup>7</sup> His argument was built on Quarles van Ufford’s (1988a: 77 in Mosse, 2005: 107) work, who in turn cites Mintzerberg’s (1979) point that organisations focus on their own implementation system goals, which are maintenance and survival of the organisation. The significant point from Mosse (2004; 2005) is that implementation activities may not work toward realising policy. If I am to expand beyond current understandings in implementation research, I have to move away from the perspective which Mosse (2005: 103) challenged, which is the “policy-centred view”. When examining implementation, I therefore move away from policy as the primary lens through which to interpret my observations on implementation practices.<sup>8</sup>

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<sup>7</sup> May and Winter (2007: 1) note that divergence between policy expectations and implementation outcomes is generally accepted within the public policy implementation literature.

<sup>8</sup> Moving away from a policy-centred focus is the basis of bottom-up approaches to studying implementation. In their discussion of “implementation as interaction” Wildavsky and Majone (1979: 167) note that the implementation problem “is not whether implementers conform to prescribed policy,

Following Mosse (2005), it is more important to examine implementation activities and establish what goals these activities realise. If implementation activities are realising alternative policy goals, then thinking of implementation gaps as failures could obscure other important insights that could extend our understanding of public policy implementation processes.

The important question then is how else we can interpret implementation gaps? Pretorius (2003) noted that workshop papers focusing on the growing gap between policy and practice in different policy sectors in South Africa addressed two questions either fully or partially. The first question was whether policies realised their intended purposes and the second question was what possible relationships exist between policy change and implementation (Pretorius, 2003: 7). He notes that three articles by Van Zyl, Pottie and Louw respectively raised a question that was implied in the other articles of the special edition of *Politeia* (2003) on implementation gaps in South Africa. The question was: “To what extent do policy processes of implementation, reflect, entail or even engender, processes of policy (re-)making?” (Pretorius, 2003: 15). In other words, to what extent does policy change occur during the implementation process? In this dissertation I explore the relationship between policy change and implementation. I argue that implementation gaps could at times signal policy change instead of failure.

If we think about Mosse’s (2004, 2005) point about implementation activities working to realise other policy goals, then it is important to note that these alternative policy

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but whether the implementation process results in consensus on goals, individual autonomy, and commitment to policy on the part of those who must carry it out.”

goals could be important indicators of policy change. The policy goals which implementation activities realise would also signal the source of the alternative policy goals. In this instance policy change would be identified when selected implementation activities realise alternative goals to those set in national policy frameworks. If we are going to explore policy change as a possible alternative interpretation of implementation gaps, then there are number of questions to address. The first question is what implementation activities were undertaken for DHS implementation in the Western Cape Province? Also what goals do these implementation activities realise? The final question is: how do these goals relate to the expressed national policy goals associated with DHS implementation?

It is difficult to identify what goals – and whose – implementation activities are being realised. In order to facilitate a deeper understanding it is important to study implementation over a longer time period. In the context of this research it would mean asking what happened after the policy decision taken by the Western Cape’s provincial government in 2001. But instead of only paying attention to activities related to the decision to transfer primary health care services, I examine DHS-related activities over a five-year period after the policy decision. Policy researchers such as Sabatier (in Matland, 1995: 151) have argued that public policy researchers should attempt to conduct policy research over longer periods, for example ten years, so that we can consider policy learning. Similarly Cline (2000: 568) notes that Goggin *et al.* (1990) argued for more longitudinal research on implementation so that the research can capture the dynamics of interactions during implementation processes.

In Chapter 2 of this dissertation I discuss the persuasion framework. The persuasion

framework is a tool which may be applied to examine whether an implementation gap may be interpreted as a signal of policy change. My approach to unpacking what an implementation gap means is similar to Cline's (2000) in that we both explore the relationship between understandings of the problem and the implications of these problem definitions for the way we treat research findings. We differ ontologically, however, as Cline seeks to ascertain the 'truth' about a model's definition of the implementation problem, the implications for the accuracy of the model and its utility in a practical context. I aim to demonstrate how our assumptions about the appropriate relationship between policy and implementation frame our interpretation of implementation gaps as a negative phenomenon. It is this frame that precludes the exploration of other interpretations of any alternative meanings of implementation gaps. I expand on this theme in the second chapter of this dissertation.

#### **1.4 Research design and methods**

The research question that informed planning for fieldwork was: why was the decision to transfer primary health care services not implemented? I explored this question using a case study research design. Yin (2003) notes that the case study is useful as the types of research methods that can be incorporated into the research design are not limited.

My aim was also to gain an in-depth understanding of DHS implementation in the Western Cape Province. I expected that using different research methods would assist in providing material that would deepen my knowledge of the complexities of implementing health system reform, while at the same time facilitating my understanding of why the decision to transfer primary health care services to the City of Cape Town was not implemented. I collected data through semi-structured interviews,

documents and observation. I elaborate on the research design in Chapter 3.

A number of individuals have contributed to the insights that I have gained on health system reform in the Western Cape Province. In order to protect the identities of these persons I refer broadly to the organisational affiliation of these persons. I am grateful to the nurses and sisters from both the Provincial Government of the Western Cape Province and the City of Cape in two community health centres; to managers and senior managers at the Metropole District Health services; to senior managers in the national health department; to a senior manager from the National Treasury and to senior managers in the Western Cape Department of Health; to a researcher from the Health Systems Trust; to the health sub-district managers in the metropolitan municipality and to a senior manager in a district municipality in the Western Cape Province; to IMATU trade union officials; and to the members of the health forum and to those who were formally active in the provincial health sector.

### **1.5 Conclusion**

This chapter has indicated that health system transformation in South Africa first means changing an unequal, fragmented health system into one that facilitates broader access to primary health services through the public health sector. The second aspect of health system reform is changing the management structure by creating health districts and management who will plan health services in each district according to community needs.

The implementation gap identified in the Western Cape Province highlights the challenges of creating a district health system based on a primary health care approach.

While it is important to understand the factors that led to this implementation gap, focusing on these factors alone would not provide helpful insights that could contribute to extending our understanding of public policy implementation. Therefore I examine the implementation gap in the Western Cape Province with the aim of establishing whether such gaps could at times signal policy change instead of failure.

The remainder of the dissertation is structured as follows: Chapter 2 provides the context within which we interpret implementation gaps as failure and offers reasons why this interpretation is not always appropriate. It then describes the persuasion framework as a means to test whether policy change is not a more appropriate interpretation of an implementation gap. The persuasion framework identifies conditions under which it is most likely that policy change would occur during public policy implementation processes.

Chapter 3 describes the research design and methodology that informed the fieldwork process. I pay particular attention to the competing methodological paradigms amongst those who study public policy processes through the notion of policy change and those who study the process through stage-specific investigations of, for example, public policy implementation. The methodological discussion demonstrates how ideas about the role of research frame the research objectives and by implication exclude other research directions that support different goals. The second section describes the research approach in terms of the preparations that informed fieldwork and the selection criteria for interviewees. The last section of the chapter discusses the significant decisions taken in the field. These decisions deviated from the initial fieldwork planning process, but they were important because they contributed to

directing attention to significant developments in DHS implementation within the PGWC.

Chapters 4 and 5 present the empirical findings on DHS implementation in the Western Cape Province. These two chapters present descriptions of significant implementation decisions and activities undertaken for DHS development in the Western Cape Province between 2001 and 2006. The empirical material is presented in two separate chapters because there are important differences in the approaches to implementing a DHS in two areas of the Western Cape Province. I classified these areas based on whether they were metropolitan or non-metropolitan municipalities. Chapter 4 describes DHS implementation in the metropolitan municipal area, which comprises the City of Cape Town municipality. Then Chapter 5 draws attention to developments in the non-metropolitan area, comprised of district and local municipalities. I will elaborate on the differences between these municipalities in the relevant chapters.

In Chapter 6 I discuss the key research finding that emerge from the two empirical chapters, which is that there has been a shift in the way that DHS implementation is taking place in the Western Cape Province. The shift in the approach to DHS implementation is significant, because it realises alternative policy goals to the expressed expectations in national health policy documents. In the first part of this chapter I discuss the mismatch between the expressed PGWC policy expectations, the national health policy expectations and the implementation activities associated with DHS implementation in the Western Cape Province. In this chapter I begin to apply the persuasion framework. I discuss the conditions and the motivating factors that would facilitate policy change.

Chapter 7 continues the interpretation of the fieldwork findings using the persuasion framework. This chapter aims to explain how policy change occurred. In this chapter I draw on John's (1998) evolutionary theory of policy change to explain how policy change occurs.<sup>9</sup> I explore how the ideas of a policy advocate are related to the interests of policy makers (John, 1998). Bacchi's (1999) concept of "problem representation" is applied when analysing the responses from key respondents who were involved in DHS implementation in the PGWC and the municipalities. I relate ideas about health service integration to my construction of policy maker interests in the PGWC. The construction of policy makers' interests is based on Welch's argument that policy makers act to avoid what he terms "continual painful losses" (2005: 8). I focus particularly on what the decentralisation of primary health care services to a municipality would have meant for the PGWC's health portfolio. Furthermore, I describe the policy makers' interests in relation to the broader context in which DHS implementation should be understood as well as the provincialisation of personal primary health care services. This broader context covers the PGWC's economic development plan, *Ikapa Elihlumayo* (The Growing Cape), the National Department of Provincial and Local Government's review of the provincial governments, and the development of intergovernmental relations in post-apartheid South Africa.

Chapter 8 concludes the dissertation. It presents summaries of the research problem, the main findings and the key elements of the persuasion framework. I then present the reasons, which I explored throughout this dissertation, which support my argument that

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<sup>9</sup> Steinmo (2003) offers an evolutionary explanation of the convergence of tax policy. Both Steinmo (2003) and John (1998) focus on ideas. Steinmo (2003) focuses on the institutionalisation of ideas to explain convergence (or a form of stability), while John's (1998) selection mechanism is an explanation of policy change.

policy change should be explored as an alternative interpretation of implementation gaps. Then finally I highlight additional research themes on health system reform in South Africa for future research.

## **Chapter 2: Reinterpreting the implementation gap as a signal of policy change**

### **2.1 Introduction**

Implementation is commonly understood as turning policy decisions into action. Howlett and Ramesh (2003: 184) define implementation as “the process whereby programmes or policies are carried out, the translation of plans into practice.” Implementation gaps became a significant research focus in public policy implementation studies after Pressman and Wildavsky (1984) highlighted the fact that implementation did not produce in Oakland what policy makers in Washington had expected. Thus an implementation gap exists when implementation outcomes do not conform to policy expectations. In the introduction to their book, Mazmanian and Sabatier (1989) noted that mismatches between policy and practice were perceived as failure and this drove the research programme on public policy implementation.<sup>10</sup>

How can we change the lens that we use to study implementation? What can we learn from implementation research by changing the focus? I argue that policy change emerges when we think differently about the research problem being studied here. When we focus on implementation gaps and we interpret these gaps as a sign of failure, then the focus of the research is directed toward providing explanations for this failure. I argue that in order to move forward in our understanding of how implementation works, we have to examine whether policy change is not in some instances a more appropriate interpretation of what an implementation gap means. This chapter provides the theoretical groundwork for establishing whether policy change has occurred and for explaining how policy change could have taken place.

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<sup>10</sup> de Leon (1999a: 328), writing ten years after Mazmanian and Sabatier (1989), describes mainstream implementation research in the following way: “...its focus on exceptional failure to the preclusion of the workaday successes have largely been ingrained, thus biasing the implementation research product.”

First, I sketch the context within which this change in focus should be understood. I outline how public policy implementation researchers have approached the study of public policy implementation. A key feature of implementation research that I discuss is the prominence of implementation gaps as a research focal area and the interpretation of such gaps as a signal of failure. I explain why implementation gaps are a prominent focus by discussing the key frames that inform our thinking about the appropriate relationship between policy and practice. These frames are the policy cycle approach and the normative expectations of representative democracy. The key point which this discussion highlights is that implementation gaps is a research problem that is constructed from a normative assumption about the nature of the relationship between policy and implementation.

Second, I discuss three reasons why the normative assumption, which is that policy drives implementation, must at times be consciously discarded. The first reason is that the meaning of the policy is not always clear. The second reason is that policy is not always made for implementation (Barrett, 2004; Mosse, 2004, 2005) and finally that implementation activities are not always geared toward implementing policy (Mosse, 2004, 2005). These insights were gleaned from those who study public policy and those who study development policy from an anthropological perspective. This discussion is important because it demonstrates that implementation gaps can only offer a partial picture of the implementation story. In turn, failure is only one possible interpretation of implementation gaps.

Third, I present the theoretical basis for reinterpreting implementation gaps as potentially signalling policy change. In the first discussion I present a different lens that we can use to study implementation in order to establish whether policy change has occurred. To establish whether policy change has occurred, we direct our attention to the policy goals that implementation activities realise. In the second discussion in this section I present the persuasion framework. The persuasion framework is a tool that may be applied to explain how policy change occurred.

## **2.2 Public policy implementation studies and implementation gaps**

In this section I discuss the context from which implementation gaps emerged as a significant research problem. I first discuss four features of public policy implementation studies: the top-down/bottom-up debate, attempts to move away from top-down or bottom-up debate, the debate on the utility of continued implementation research and the competing methodologies that inform implementation research. The discussions highlight the purpose of implementation research. Furthermore, and more importantly, these discussions highlight that the implementation gap is a prominent research problem and it is within this context that an implementation gap would be interpreted as a signal of failure.

The interpretation of implementation gaps as a signal of failure is based on a normative assumption about the relationship between policy and implementation. I discuss where this normative assumption stems from. I pay particular attention to two frames that influence our interpretations of implementation gaps. I discuss the how the policy cycle approach and the normative expectations associated with representative democracy affect how we understand the relationship between policy and implementation. These

frames are important because the normative assumption that these frames promote has led to implementation gaps being interpreted as a sign of failure. If we are to find alternative interpretations, then we need to be cognisant of the effects of such frames.

### *Key features of implementation studies*

In this section I discuss some of the key features that characterise public policy implementation research. The first feature is the debate from the 1970s onward about whether to study implementation from the top down or from the bottom up.<sup>11</sup> Applying the top-down approach meant studying policy makers and policy. Top-down researchers present the implementation process as one of command and control. According to Parsons (1995: 466), the rational model informs this approach and directs attention to control, directing the implementation process and “getting people to do what they are told” so that the policy goal may be achieved.

Well known top-down researchers such as Pressman and Wildavsky (1984) started the process of unpacking the factors that affect implementation from 1973, when their book was first published. In their book entitled *How great expectations in Washington are dashed in Oakland* they highlighted numerous factors that explain why a federal government employment programme was not implemented as expected in Oakland. Their work represents the beginning of the implementation gap as a key research focus in public policy implementation studies. The implementation gap, as implied in the title

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<sup>11</sup> This research was done in the broader government context of the 1970s. It also refers to the vision that Lasswell had for a policy sciences that provides policy-relevant research informed by multiple disciplines (Howlett and Ramesh, 2003: 3). The broader aim of public policy studies was to offer policy makers advice. Fischer (2003) describes how the importance of the policy field grew, particularly in the USA. He highlights some of the dominant ideas that informed the direction of most of the public policy literature which emanates from the USA. The goal was still to inform the policy process.

of the work, is the mismatch between what the federal government wanted and the outcomes that they observed in Oakland.

The aim of implementation research at the time was to develop advice to decrease the gap between policy and implementation (Matland, 1995: 147). The factors that researchers highlighted were mainly technical. For example, Pressman and Wildavsky (1984) highlighted factors such as an absence of advanced funding, increased numbers of participants, delays leading to cost escalation over time, and different perspectives within the implementation agency, the Economic Development Agency (EDA). They also noted that implementation difficulty increases when the number of “decision points” increases as this extends the “chain of causality” (Pressman and Wildavsky, 1984: xxiv).

Some researchers point out that the focus on top-down approaches is re-emerging. Barrett (2004: 249) notes that researchers have in recent times paid more attention to change management and performance targets than implementation, and this focus has reintroduced the command and control perspective associated with top-down approaches. These points of focus reflect the introduction of business management perspectives, which have to some extent replaced the language of public administration (Barrett, 2004: 258). In the environment where business management has become more prominent, success and failure are based on whether policy targets have been met or not (Barrett, 2004: 258). The emphasis on evaluation based on whether policy goals have been attained means that we should expect to see an increase in cases of implementation failure. This is problematic because “the link between policy intent and policy action is problematic, as the accumulated evidence has now demonstrated

beyond doubt” (O’Toole Jr, 2004: 309).<sup>12</sup> This is important because it shows a return to the focus on implementation gaps and notions of success and failure.

Bottom-up researchers also wanted to contribute to knowledge about public policy implementation processes that would inform public policy processes. They paid more attention to “describing what factors have caused difficulty in reaching stated goals” (Matland, 1995: 149). The research focus turned to how those who are actively involved in implementation and who affect how implementation processes work. Lipsky’s (1980) work was significant here. He highlighted the role of those at the frontline of service delivery in the implementation process, whom he called “street-level bureaucrats” (Lipsky, 1980: 3). Lipsky noted that street-level bureaucrats developed coping strategies to balance policy demands with the demands of their environment (Lipsky, 1980: 18), and these actions affected policy outcomes because street-level bureaucrats could determine the quality of service delivery (Lipsky, 1980).<sup>13</sup> Lipsky (1980) highlighted the importance of studying discretion and the impact of discretion on outcomes.<sup>14</sup> Elmore (1980) offered “backward mapping” as a framework that policy actors could apply within policy processes. Elmore argued that “It is less important to agree on a single framework for analysing implementation problems than it is to be clear about the consequences of adopting one framework over another” (Elmore 1980: 602).

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<sup>12</sup> O’Toole Jr (2004) mentions this point when discussing the problematic relationship that exists between policy research and its use in public policy processes.

<sup>13</sup> Hicklin and Godwin (2009) have highlighted the idea that more attention needs to be paid to managers. They note that managers and street-level bureaucrats face different incentives (Hicklin and Godwin, 2009: 14). They note that bottom-up approaches, which focus on street-level bureaucrats, ignore the fact that “top-down management adapts and responds to changes in policy environments, personnel, and political directives” (2009: 15).

<sup>14</sup> In a recent debate about the utility of continued implementation research Barrett (2004) argued that the problems related to understanding the role of discretion and motivation in implementation require further attention. Schofield (2001: 253) similarly noted that researchers should examine role of bureaucratic discretion in implementation to understand the disjuncture between policy and practice.

A second key feature of public policy implementation studies was the move beyond whether to study implementation from the top down or the bottom up.<sup>15</sup> The emphasis turned to understanding implementation processes within context (Parsons, 1995: 471-472) and to paying attention to the relationships that affect implementation outcomes.<sup>16</sup> Researchers who made a contribution here offered more complex pictures of implementation based on a synthesis of insights from top-down and bottom-up approaches. The models presented implementation as an interactive process (Barrett and Fudge, 1981) and a communicative process (Grin and van der Graaf, 1996).

Contributions to the public policy implementation process since the top-down or bottom-up debate depicted interactive and complex implementation processes. Barrett and Fudge's (1981) work on implementation as a policy action continuum is a noteworthy contribution. They directed attention to a particular kind of relationship between policy making and implementation. Barrett (2004: 253) explained that the focus on policy and action was an attempt to move away from a policy-centred perspective on implementation and the assumption about the hierarchical relationship between policy making and implementation. The reason is that a policy-centred perspective "plays down issues such as power relations, conflicting interests and value systems between individuals and agencies responsible for making policy and those

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<sup>15</sup> de Leon, (1999a: 322) criticises attempts to synthesise top-down and bottom-up approaches when he notes that they stem from "different worlds" and they have different assumptions. He notes that top-down approaches are deductive, while bottom-up approaches are inductive.

<sup>16</sup> Grin and Van de Graaf (1996) also focus on relationships between actors associated with implementation processes. Their model is based on "communicative interaction between policy actors and their target groups" (1996: 292). Others who have chosen to synthesise the bottom-up and top-down approaches have, for example, examined the interaction between factors that affect public policy implementation processes. Matland's (1995) ambiguity-conflict model discusses how the interaction between different levels of ambiguity and conflict, which are associated with a policy, leads to different implementation processes.

responsible for taking action” (Barrett and Fudge, 1981: 4). Implementation was thus viewed as a “policy-action dialectic involving negotiation and bargaining” and the interaction was between those who wanted policy to be implemented and those who were responsible for action (Barrett and Fudge, 1981: 4; Barrett, 2004: 253). This emphasis on interpersonal relationships highlights an important complicating factor in implementation processes.

A third feature of the public policy implementation literature was the debate about the utility of continued implementation research. In the late 1990s Hill (1997b in Hill and Hupe, 2002: 1) and de Leon (1999a: 313) had asked whether studying implementation was still worth the effort. The reason for this question was the lack of progress on implementation theory (de Leon, 1999a: 314; de Leon, P. and de Leon, L., 2002: 471). They noted: “However, even though an enormous set of books and articles deals with implementation, it has been described as leading to an intellectual dead end because of its problematic relationship to a generalized theory of policy implementation” (de Leon and de Leon, 2002: 467). The question that started the debate linked the intellectual development of public policy implementation studies with developing generalisable theory. The focus on the development of generalisable theory highlights the positivist underpinnings of the field.<sup>17</sup>

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<sup>17</sup> Developing generalisable theory is a theme that public policy process scholars explore. Sabatier, a former public policy implementation researcher, had moved away from implementation-specific research. He did not view stage-specific research as a way of moving ahead with developing theory (Sabatier, 1991: 147). Sabatier and Jenkins-Smith (1993: 9) argue that researchers should move away from the stages approach toward developing theories of the policy process. These theories of the policy process should be a closer match to the descriptive reality; they should be empirically testable and they should offer some significant causal factors (Sabatier and Jenkins-Smith, 1993: 9). He and Jenkins-Smith (1993) developed the Advocacy Coalition Framework, which is continually being developed and tested in different policy areas.

The response to the question was yes, but for different reasons. de Leon and de Leon (2002: 483) noted that implementation theory must be based on democratic values and they offer a democratic approach to policy implementation.<sup>18</sup> Hill and Hupe (2002: 1) highlighted a few reasons why implementation research should continue, but in particular they note the need to explore implementation in the context of governance.<sup>19</sup> O'Toole (2000: 3) argued that implementation research remains important because the goal is still to develop scientifically obtained deductive theories on implementation. Saetren (2005) conducted an extensive review of where implementation work is being done. He notes that there is no paucity of implementation research as a number of researchers conduct implementation research in a number of policy issue areas, but they do not associate their work with public policy implementation literature<sup>20</sup> (2005: 563-564).

Two researchers emphasised the role of discretion as a theme that requires further research. Barrett (2004: 249) noted that there is still much to understand about implementation processes and she highlights issues such as the problems related to understanding the role of discretion and motivation in implementation. Schofield<sup>21</sup>

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<sup>18</sup> They refer to this approach as an alternative means to design implementation studies and practice (de Leon and de Leon, 2002: 487). They note as one of the arguments that there must be something wrong if implementation failure is so pervasive (de Leon and de Leon, 2002: 487). They mention the fact that Kelman, a researcher who worked in the federal bureaucracy in the USA, later questioned whether implementation scholarship was practical for operational application (de Leon and de Leon, 2002: 487).

<sup>19</sup> Robichau and Lynn Jr. (2009) note that public policy theories and governance theories both examine the relationship between policy making and effects that follow policy making. They argue that public policy process theories do not distinguish between policy outputs and policy outcomes, and hence public policy theories present a less than impressive picture of the administrative processes of implementation (Robichau and Lynn Jr., 2009: 22, 27). Furthermore, they point out that administrative systems play a mediating role between policy making and consequences, and therefore they note that the role of administrative systems is not addressed appropriately.

<sup>20</sup> Health policy researchers have started to apply bottom-up approaches when analysing the implementation of health policy reforms. Examples are Walker and Gilson (2004), who focus on nurses' responses to health policy reforms such as free primary health care in South Africa.

<sup>21</sup> Schofield (2001) recommends themes similar to those that public policy scholars who work on policy process theories examine. This suggests that public policy implementation researchers can develop their

(2001: 253) similarly emphasised that there is still much to learn. She noted that researchers should examine how knowledge, learning and capacity operate during implementation processes and role of bureaucratic discretion in implementation to understand the disjuncture between policy and practice (Schofield, 2001: 253). Another argument in favour of continued public policy implementation research is that there is a need to develop appropriate advice for policy actors. For example, Barrett notes also that we need to “invest in studies of implementation and change processes, both conceptual and empirical” and that these studies should contribute to our understanding of the “dynamics of the policy-action” relationship... with the view to providing more appropriate prescriptions for change than management approaches currently do (Barrett, 2004: 260). The persuasion framework, which I discuss in the third section of this chapter, addresses some of the themes. I describe the role of discretion and motivation in facilitating policy change during implementation.

A fourth key feature of public policy implementation studies is that those who study implementation pursue different research goals and these research goals indicate different methodological orientations amongst researchers.<sup>22</sup> In Fischer’s discussion on key aspects of public policy studies he notes that public policy studies have a limited methodological framework because of the “neopositivist/empiricist methods that dominated the social sciences of the day. This has generated an emphasis on rigorous, quantitative analysis, the objective separation of facts and values, and the search for generalizable findings” that can explain phenomena irrespective of context (Fischer,

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understanding of implementation processes by exploring themes that are not usually examined in the implementation literature.

<sup>22</sup> de Leon (1999a: 323) refers to work based on interpretive orientation as a new development in implementation research with the theme of democratic participation and notes that these developments could directly affect renewed studies on implementation. de Leon and de Leon (2002) contributed to renewed implementation research through their democratic approach to implementation.

2003: 4). There are other policy implementation researchers who share this view of how the implementation studies can develop as a field. For example, Goggin (1986: 334) argued that third-generation public policy implementation researchers should begin to integrate the findings in the implementation literature by developing theory. They should attempt to develop theory by moving away from case studies on implementation to using statistical methods to test relationships between different variables (Goggin, 1986: 334-335). O'Toole (2000: 3) argues that implementation research remains important because the goal is still to develop scientifically obtained deductive theories on implementation. Matland (1995: 146) argues that the implementation literature needs "structure" to process the 300 significant variables that O'Toole identified. Generalisable theory is one way in which to create such structure. Other researchers have attempted to process the extensive lists of factors by developing models that depict the way that various factors that affect implementation interact. For example, Matland (1995) offers the ambiguity-conflict model, which identifies different types of implementation based on whether the level of policy ambiguity and conflict is high or low.

Another methodological orientation that informs thinking about how the policy implementation world works and how we can access knowledge about this world is an interpretive orientation. Yanow (1987, 1993) and Fischer (2003) are two contributors to this interpretive turn in public policy studies. Fischer (2003: 49) describes an interpretive perspective as comprising two principles: meaning is important in the construction of social reality, and social meaning can change. According to Yanow (1993: 41), if we apply an interpretive approach to studying implementation we ask questions such as "what does a policy mean; to whom, aside from its drafters and

implementors, does it have meaning; and how do various interpretations of meaning affect policy implementation?" By paying attention to meaning, we acknowledge the importance of language in the policy process. In his book entitled *Evidence, argument and persuasion in the policy process* Majone (1989: 1) points out that language needs attention in policy analysis, because "As politicians know only too well and social scientists too often forget, public policy is made of language."

Understanding implementation from an interpretive orientation also draws attention to the way that researchers ascribe meaning to their observations on implementation. For example, when Yanow (1987: 103-104) discusses a policy culture approach to implementation, she describes the thinking that has informed interpretations of observations on implementation. Yanow (1987) highlights the shared assumptions and the ontological logic which bind the four competing lenses that explain implementation. The first assumption is that implementation problems must derive from the implementation process, because when implementation begins, the policy-making process has ended (Yanow, 1987: 107).<sup>23</sup> Secondly, implementing agencies work with the literal meaning of policy, which means "the language of the policy mandate" (Yanow, 1987: 107). Thirdly, it is assumed that implementers want to implement the written policy and something other than their intentions interferes with implementation (Yanow, 1987: 107).<sup>24</sup>

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<sup>23</sup> This assumption reflects the underlying logic that informs the public policy stages approach. This assumption also reflects what Pressman and Wildavsky (1984: xxi) said when they conceptualised implementation in that they argued that implementation suggests that there must be something which has been developed that must be put into effect. They noted that not having something prior to implementation, such as policy, means that you do not have a standard against which you can judge whether there is evidence of success or failure.

<sup>24</sup> Yanow's (1987) assumptions two and three draw attention to the nature of policy, in particular the form that it takes and assumptions about policy actor behaviour in the policy process. Regarding the latter, she highlights the fact that we assume that implementers want to implement policy and thus we direct attention to the forces that prevent them from doing what they want to do, which is to put policy into effect.

These assumptions are informed by other frames. Yanow (1987: 107) notes that the underlying frame that informs these assumptions is a normative stance, which is that “something is not working the way it is supposed to, something is broken, and it needs fixing.” The fact that something is understood as wrong is informed by a particular methodological orientation. Yanow (1987: 108) links these assumptions to a positivist worldview. She thus notes that the question that informs implementation analysis is: “What is the objective nature of implementation?” (Yanow, 1987: 108). In other words, what is the character of implementation processes if we discard the problematic relationship between policy and implementation, if we factor out that policy meaning can change because implementers interpret policy differently, and if we do not admit that implementers have interests that shape how they understand policy and how they act.

Yanow’s (1993) work on how policy meanings are communicated demonstrates that failure is a matter of perspective. Those who evaluate implementation may apply different evaluation criteria, which would affect interpretations of success and failure. For example, Yanow (1993:42) notes that if the objective and factual measures were applied to the case of Israel Corporation of Community Centers then the verdict would have been that they failed because they did not implement their mandate. However, the stakeholders viewed the agency’s work as a success (Yanow, 1993: 42). Thus interpretations of success and failure depend on the angle from which the implementation outcomes are interpreted.

In the next section I apply an interpretive lens by asking about the frameworks within which meaning has been assigned to implementation gaps in the implementation literature. This exploration of what frameworks have shaped meaning in the implementation literature is important because it demonstrates the assumptions that underpin our interpretations of the implementation stories that we explore through studying implementation.

*Implementation gaps as signals of failure*

de Leon and de Leon (2002: 476) note that an underlying assumption in implementation studies is “that programs usually fail, despite the best intentions of the public administrators.” They note further that analysts and administrators should not be surprised that case studies show “various degrees of failure. For one thing, the attention of both scholars and practitioners is focused on problems, that is, situations in which reality diverges from expectations” (de Leon and de Leon, 2002: 477). Public policy implementation researchers have focused much attention on explaining implementation gaps because this is perceived as a problem that research needs to resolve (May and Winter, 2007; Schofield, 2001). Schofield (2001: 247-248) points out that implementation researchers have produced typologies of approaches that aim to develop a closer link between implementation and the policy goal, meaning the typologies have offered advice on how to resolve the problem represented by implementation gaps.

But can implementation gaps always best be interpreted as signalling failure? “In the light of these difficulties, perhaps implementation failures are really just overt failures of optimistic expectations” (de Leon, P. and de Leon, L., 2002: 476). The latter point

goes to the heart of the argument in this section, which is that failure is an interpretation of implementation gaps which is based on “optimistic expectations”. These expectations are informed by the assumption that policy should drive implementation. Parsons (1995: 466) notes that the assumption that policy drives practice is a normative assumption, which means that it is based on what the case should be rather than what the case is. This normative assumption is a key frame through which we interpret public policy implementation.

Implementation gaps demonstrate that policy does not drive implementation. Hence because implementation outcomes do not reflect policy expectations, implementation gaps are interpreted as a sign of failure. The assumption that policy should drive implementation is established through a number of influential frameworks that have contributed to thinking about public policy studies. Parsons (1995) provides an extensive review of a number of models, theories and frameworks from various disciplines that have informed public policy studies. I draw attention only to those which support the assumption that policy should drive implementation. The influential frameworks are the policy-cycle approach and the normative expectations associated with representative democracy.

The policy cycle approach is the most important framework that supports the assumption that policy drives implementation.<sup>25</sup> According to Nakamura (1987: 142),

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<sup>25</sup> Public policy researchers have debated the merits of the policy cycle approach for both teaching and research. For example, Hill and Hupe (2002: 6) argue that the policy cycle approach is still useful, because each phase of the cycle is a partial representation of the public policy process. So when we study the respective phases, we could provide an insight into the complexities of the different parts of the policy process. Howlett and Ramesh (2003) similarly support the continued use of the policy cycle approach. They attempt to unpack the dynamics of public policy processes by focusing on the policy subsystems within each stage of the policy process. They bring together the insights from each of the stages by asking whether there are “overall patterns of policy development and change” (Howlett and Ramesh, 2003: 228).

the policy cycle approach shapes how we think and talk about policy processes. In the field of public policy studies the policy stages approach is the main approach to teaching and studying public policy processes. The key feature of this approach is that it conceptually splits the public policy process into stages. There are many variations of the stages approach. Howlett and Ramesh (2003: 13), in their book *Studying Public Policy: Policy Cycles and Policy Subsystems*, offer their own version of the policy process, which consists of the following policy stages: agenda setting, policy formulation, decision making, implementation and evaluation.

The policy cycle approach draws our attention to the role of the rational model in shaping thinking about the relationship between policy and implementation. The logic that informs the policy cycle approach is applied problem solving (Howlett and Ramesh, 2003: 13; Colebatch, 2006: 309). Howlett and Ramesh note that the problem-solving logic suggests that the public policy process operates as a cycle (Howlett and Ramesh, 2003: 13) and add that others who have developed alternative versions of the policy cycle approach do not indicate that problem-solving logic informs this approach (Howlett and Ramesh 2003: 6). The applied problem-solving logic that informs this approach presents problem solving as a set of procedures that follow on from one another to resolve the problem. The phases of applied problem solving are problem recognition, proposing a solution, choosing a solution, putting the selected solution into effect, and finally monitoring the results (Howlett and Ramesh, 2003: 13). The logical progression from one phase to another phase of problem solving presents policy as something that always precedes implementation and implies that policy has a fixed meaning because it is the adopted solution to the problem. In other words, policy makers always take decisions before implementers begin to put a policy solution into

effect. Thus when we hold implementation outcomes up to the light of policy expectations, we are in effect evaluating the practical relationship between policy and implementation against the rational ideal as projected through the policy cycle approach.

Nakamura (1987: 142), in his critique of the policy cycle approach, refers to this approach to studying public policy as “a textbook conception of the policy process”. He notes that the policy cycle approach had become so ingrained because it resonated with the rationalist underpinnings of the disciplines associated with policy studies and the language and activities of those in the policy process (Nakamura, 1987: 143). He argued that this approach was problematic because it “does not describe the process of policymaking, it mis-states the problems of implementation, and it confuses the issues involved in evaluation” (Nakamura, 1987: 145). A particularly interesting point here is that the policy stages approach has shaped the perception of problems that exist within the policy process. This raises a question regarding implementation gaps. Is an implementation gap a “mis-stated” implementation problem?

Expectations regarding the nature of the relationship between policy and implementation also derive from the expectations of the role of politicians and implementers in a representative democracy. Nakamura (1987: 144) notes that the policy cycle reflects the democratic norms that underlie public action. Democracy, in terms of the Greek origins of the word, means “rule by the people” (Heywood, 2007: 72). Democracies across the world tend to be representative, as direct rule is limited in the world by the size of the eligible citizenry who comprise ‘the people’ in many states. The democratic expectation that affects how we understand the relationship between

policy and implementation is the notion of accountability. Heywood (2007: 418) defines accountability as “answerability: that is, a duty to explain one’s conduct and be open to criticism by another”. In practical terms accountability means that the people’s representatives should explain their action or lack thereof to the people. Because people elect representatives to take decisions on their behalf, the expectation is that politicians as the peoples’ representatives are the only legitimate policy makers. Implementers, meaning civil servants, cannot take policy decisions and their role is merely to give effect to national policy makers’ decisions. Politicians and implementers thus have separate roles in the policy process. The role of policy decision making belongs to policy makers.

### **2.3 Questioning the assumption that policy always drives implementation**

Some public policy implementation researchers and anthropologists<sup>26</sup> question the assumption that policy drives or directs implementation. The first reason for doing so is that it is not always clear what policy means. Second, policy and implementation are not always geared toward their assumed function, but they may fulfil other functions (Barrett, 2004; Mosse, 2004, 2005). So policy is not always developed to direct or guide implementation, and implementation is not always geared toward putting policy expectations into effect. These are important insights, which suggest that one should explore an alternative interpretation of implementation gaps. The alternative should give less importance to the assumption that policy drives practice, as this relationship may be contested.

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<sup>26</sup>There is an overlap in the focus areas regarding implementation research in Mosse’s work and the public policy implementation literature. Mosse (2004) points out that those who study development also consider the divergence between implementation outcomes and development policy expectations as a problem that needs to be resolved. The perceived solution amongst development researchers is developing better theory (Mosse, 2004: 1; 2005: 2). Some public policy implementation scholars have also sought to develop generalisable theory on implementation in order to eliminate the gap between policy expectations and implementation practice.

*Difficulties with establishing what policy means*

When we identify an implementation gap, we have evaluated implementation by comparing implementation outcomes with policy expectations. The core reason why evaluating implementation in this way could be problematic is that it is not always easy to establish what policy means.<sup>27</sup> Below I discuss why it is difficult to establish what policy means.

Questions about the meaning of policy have been raised from the fields of both anthropology and public policy research. First, Nakamura (1987: 147) notes that the policy process approach leads us to assume that policy decisions are stable. This approach thus leads to the perception that once a decision has been taken, no one changes their minds and that the decision stands even though circumstances may change. Nakamura's point indicates that policy meaning is difficult to establish because policy decisions are not stable and those who support policies may change over time and thus decisions may also change.

Second, it is difficult to establish what policy means, because legislation and objectives do not provide much insight into policy meaning. Mazmanian and Sabatier (1989: 3-4) noted that we cannot rely on objectives to tell us about outcomes as they are merely general hints about what will actually be done by an administrative agency. Majone (1989: 26) noted that "legislative mandates are often so vague, ambitious, or

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<sup>27</sup> Public policy implementation researchers have been debating whether one can distinguish between policy formation and policy implementation (Hill and Hupe, 2009: 63). Hill and Hupe note that those who argue that implementation is part of policy-making processes, such as Palumbo and Calista (1990 in Hill and Hupe, 2009: 63), do tend to base their argument on the fact that "policy design is not always clear and the renegotiation of details with a multiplicity of actors affected by that policy is an accepted part of the policy process" (Hill and Hupe, 2009: 63).

contradictory that there are no clear standards for administrators and experts to apply.” Yanow (1987: 109) notes that policy ambiguity is sometimes purposive. One reason for this is that the legislation must reflect the various interests if it is to be passed (Yanow, 1987: 109). Policy implementers are thus inadvertently given the job of interpreting policy. Yanow (1987: 108) notes that they interpret policy in the existing policy culture, which “includes the historical record of values and beliefs about that issue.” For the analyst it then becomes increasingly difficult to establish what policy means, because one has to understand how implementers have interpreted policy in terms of the “policy culture”.

Third, it is often difficult to establish what policy means because policy is subject to interpretation. de Leon and de Leon (2002: 480) refer to this as the “problem of *administrative legitimacy*” in public administration. They indicate that statutes cannot provide clear direction for implementation and thus laws require interpretation at a lower level (de Leon, and de Leon, 2002: 480). Hill (2003) similarly noted that policy is subject to interpretation and implementer learning informs these interpretations. She describes policy as generally lacking detail on implementation and therefore “street-level bureaucrats” are “performing acts of interpretation on the available texts that constitute policy” (Hill, 2003: 268). Hill (2003) draws our attention to “implementation resources”, which refers to those individuals and organisations outside of government who contribute to the way that implementers learn about policy. According to Hill (2003: 269), this perspective is important as it directs attention to changes which happen in practice and without policy. Hill’s (2003) work is important because it adds a layer of complexity to understanding implementation as we also need to unpack how policy is interpreted and who has influenced those interpretations.

Fourth, there is the question of what constitutes policy. Shore and Wright (1997) examine policy from an anthropological perspective. They ask about the nature of policy and refer to its fragmentary nature and to the problems related to developing a coherent understanding of policy, because what constitutes policy is the subject of debate (Shore and Wright, 1997: 5). They ask whether policy is the documents that governments publish or the rhetoric of key policy makers within the system (Shore and Wright, 1997: 5). Nakamura (1987: 148) also noted that the notion of policy became problematic because of the issue of whether policy is a product of the legal process or an activity to fulfil a function. Parsons (1995: 13) poses another question about the meaning of policy: is policy “an ‘intended’ course of action” or “something which is not intended, but is none the less carried out in the practice of implementation or administration?” These questions about what policy means are significant, because one is asked to think about whether policy represents a policy makers’ decision or intention, or what happens during implementation without specific authoritative sanctioning of the activities. Furthermore, we are asked to consider whether policy is only a decision or could it also refer to action?

Finally, Majone (1989) adds another dimension of complexity to the matter of the meaning of policy. Majone (1989: 158) introduces the concept of “policy space” in his book on the role of argument and persuasion in the policy process. A “policy space” refers to “a set of policies that are so closely interrelated that it is not possible to make useful descriptions of or analytic statements about one of them without taking the other elements of the set into account” (Majone, 1989: 158-159). He argues that we need to take into account that policies do not operate independently of other policies (Majone,

1989: 158-159). Thus the analyst needs to do more than identify a piece of legislation or a policy decision. In fact, the analyst is left to uncover the policies that form part of the “policy space”.

These insights indicate that we should be cautious when we use policy goals as a yardstick against which we measure implementation, because goals can be unclear and the vagueness may be deliberate. Furthermore, policy is subject to interpretation, which means that policy researchers should be cautious when assuming that the notion of policy that we use as a criterion against which we examine implementation outcomes is indeed the interpretation of policy that drove implementation. If we are interested as researchers in whether policy drives implementation, then we should explore what policy means for those who make policy and those who implement it. If we agree that interpretation is important in the policy process, then implementation gaps could also signify that policy makers and implementers did not share the same understanding of policy.

*What is the role of policy in the public policy process?*

The assumption that policy drives implementation leads one to expect that policy has been constructed to direct implementation processes. However, a number of implementation researchers note that policy is not always created to direct implementation activities toward achieving the stated goals. Instead policy sometimes serves other functions.

First, policy could be an agreement between various conflicting parties. Nakamura (1987: 148) notes that policy may be the product of compromise and this means that

after the policy has been passed, “the coalition dissolves back into its conflicting parts to dispute over the meaning during implementation.” Mosse (2004: 639; 663) explored the implementation process of a development policy and noted that “good policy” might be policy aimed at obtaining support for the policy. Therefore “good policy” does not always mean that it is good in the sense that it is the appropriate solution to a policy problem. Instead, policy is good because the conflicting parties agreed on those elements that then comprise the content of policy.

Second, policy could be seen as a tool which realises various ends. Colebatch (2006: 312) points out that there is a discrepancy between the “textbook approach” to policy and what policy actors experience in practice, which is left unexamined. He notes that the government process is complex and contains different participants who have different interests and thus “‘policy’ is a concept mobilised to secure support for particular concerns” (Colebatch, 2006: 312). He explains by referring to an example of youth policy, which he notes pits claims from education, employment and law enforcement against one another (Colebatch, 2006: 312). Policy is thus called for to address three sets of concerns that are related to the youth. Shore and Wright (1997: 11) argue that policy can serve as a rational guise for the expressions of irrational policy goals and ideologies. In other words, policy acts as a legitimating device for ideas that would usually not be acceptable. Mosse (2004: 648) makes a similar point about the role of policy in development projects. For example, he noted that the project was addressing a criticism of British aid programmes, because it was now directing attention to helping the poorest people (Mosse, 2004: 649). Barrett (2004: 251) notes that in her experience of the policy process around town planning in the 1970s in London, “policy tended to follow and serve to justify action rather than the other way

around”. Policy thus came after implementation. Once again policy was a tool to legitimise actions already undertaken.

*What is the role of implementation in the policy process?*

Amongst public policy implementation researchers, the role of implementation is generally understood as being to realise policy. In this section I discuss Mosse’s research insights from a Department for International Development (DFID) development project in western India, where he was part of the implementing team. He asked how development works. He focuses on development policy implementation and he offers a different insight into the role of implementation in a development policy process. His insights are relevant to public policy implementation studies because some of the central questions are the same.

Mosse is interested in “the relationship between policy models and the practices or events that they are supposed to legitimate” (Mosse, 2004: 640; Mosse, 2005: 1-2). He suggests that practice drives policy and that development actors are devoting their energies to maintaining coherent representations of events (Mosse, 2004: 640; Mosse, 2005: 2). In other words implementation works to secure other ends than simply to implement policy. Mosse proposes, in his chapter on implementation, that organisational interests and the need to maintain relationships direct implementation (Mosse, 2005: 103). He draws on the work of Quarles van Ufford (1988a: 77), who points out that organisations focus on their own system goals, which are maintenance and survival, rather than the minister’s formal policy goals. Furthermore, he notes that a bureaucracy is not an instrument of policy because it generates ideas, goals and

interests independently (Mosse, 2005: 103). This means that policy implementation could be tailored to maintain existing bureaucratic ideas, goals and interests.

Mosse (2004) notes that implementation can sometimes be geared toward securing other interests and argues that “development interventions are not driven by policy but by the exigencies of organisations and the need to maintain relationships” (2004: 651). For example, Mosse noted that the development workers learnt that local elites were dominating the participatory planning sessions and that the “so-called local choices were also shaped by the development agendas of government officers, scientists, foreign researchers, anthropological consultants... and agencies with whom the project had to maintain a relationship” (Mosse, 2004: 651).

Mosse’s work raises some important questions on the role of implementation in policy processes. If we cannot assume that implementation works exclusively toward realising policy, it means that we also cannot assume that those involved in implementation all have the intention to realise stated policy goals. It is therefore important that research on implementation is directed toward unpacking the interests and ideas that could be driving implementation. This is an important point for the persuasion framework that I discuss next.

In summary, the first section highlighted the point that we treat the divergence between policy and implementation outcomes as a research problem because we assume that policy drives implementation. I showed that the expectations of a representative democracy and the policy stages framework support this assumption. Then I established that holding up implementation outcomes against policy objectives is

problematic, because we cannot be sure that policy means the same for policy makers as for policy implementers. Furthermore, policy is not always made to drive implementation, but to secure other goals. Finally, we cannot assume that implementation activities are always directed toward realising policy goals as implementation can be directed toward securing other interests.

#### **2.4 Establishing whether policy change has occurred**

In this section I demonstrate how we can establish whether policy change has occurred. I begin by conceptualising policy change. Policy change is conceptualised differently in public policy studies and international relations. Hall (1993: 278-279) refers to policy change as entailing three orders of change: first-order change refers to change to the policy instrument; second-order change refers to changing the category of the policy instrument; and third-order change refers to changing the policy goals. Other public policy studies researchers refer to different types of change. Howlett and Ramesh (2003: 235) discuss normal and atypical change. When policy change is “normal”, one would expect to see small changes being made to the existing policy or programme (Howlett and Ramesh, 2003: 235). If policy change is “atypical”, then one would expect to see policy making being transformed and “basic sets of policy ideas, institutions, interests and processes” would change (Howlett and Ramesh, 2003: 235). John (2004: 253) identifies policy change through posing questions such as “Why do policies emerge?” and “Why is stability sometimes replaced with instability?” Policy change could thus mean the development of new policy and shifts in policy.

International relations researchers who study foreign policy change, such as Welch (2005), leave the analyst to define policy change. He examines state behaviour and asks

why states take the decision to go to war. This suggests that policy change means a significant shift in the approach to interstate relations. These notions of policy change share one feature, which is that policy change refers to a move away from what was done previously and this shift could be minor or extensive.

Public policy implementation researchers have identified policy change as a feature of implementation. For example, Majone and Wildavsky (1979 in Pressman and Wildavsky, 1984: 170) noted in their evolutionary take on policy implementation that “Policies are continuously transformed by implementing actions that simultaneously alter resources and objectives.” Parsons (1995: 461; 462) said “A study of implementation is a study of change: how it occurs, possibly how it may be induced” and that “implementation is policy-making carried out by other means.”

Mosse’s (2004, 2005) research indicates that we need to approach implementation with the view that mismatches between expressed policy expectations and implementation practices are inevitable, because various interests inform policy and implementation. This in turn suggests that divergence between policy expectations and implementation outcomes may not always be a problem that needs to be resolved. Instead we should make space for the possibility that mismatches could be directing our attention to something other than failure as a feature of public policy implementation processes.

In order to explore another interpretation of a mismatch between policy and implementation, I replace Mosse’s (2004: 641) question “How does development work?” with the question “How does implementation work?” There are two important points that lead me to conclude that an implementation gap could be a signal of policy

change. The first point is that implementation is also an arena for policy making. Therefore we have to ask “To what extent do policy processes of implementation, reflect, entail or even engender, processes of policy (re-)making?” (Pretorius, 2003: 15). Second, the key link between policy change and implementation is the role of implementation in the policy process. Mosse (2004, 2005) pointed out that implementation activities can work toward securing interests rather than policy goals.

To establish whether policy change has occurred, we should examine whether implementation activities are working to secure other goals than what we would expect based on expressed policy expectations. If there is a divergence between the goals that implementation activities realise and the goals that policy expectations suggest should be implemented, then policy change has occurred. When we have identified policy change, the next key question becomes: how did policy change occur? In the next section I present the persuasion framework. The persuasion framework is a tool that I developed through my research to offer an explanation of how policy change occurs.

## **2.5 Explaining how policy change occurs: the persuasion framework**

How do those who study policy change describe how it occurs? Sabatier and Jenkins-Smith’s Advocacy Coalition Framework (1993) indicates that policy change occurs when another coalition replaces the dominant coalition (Sabatier and Jenkins-Smith, 1993: 5-6). Welch (2005: 8) argues that foreign policy change occurs when policy makers take decisions based on their desire to avoid “continual painful losses”. John (1998) offers an evolutionary theory of policy change. He argues that a symbiotic relationship exists between ideas and interests and this is the basis for explaining policy change or policy stability (John, 1998: 166).

The persuasion framework is based on the notion that policy change can occur during implementation if three main elements are present. The first element is facilitating factors for policy change such as discretion and decentralisation. The second element is that there is sufficient motivation to initiate policy change. The final element is that there is a policy advocate who develops a problem representation that links a preferred policy solution with the interests of those who have the authority to take decisions on implementation strategy. The problem representation is persuasive because it is linked to policy makers' interests and thus policy change occurs. The link between the policy advocate problem representation and policy makers' interests was derived from John's (1998) evolutionary approach to policy change. I will elaborate on this later.

*Discretion and decentralisation: conditions that facilitate policy change*

In order to explain how policy change can occur from below and during implementation, it is important to establish to what extent policy actors can initiate policy change, as not all policy actors are authorised to take policy decisions. Howlett and Ramesh (2003: 163) note that "the numbers of relevant policy actors decreases substantially with the progress of the public policy process to the decision-making stage." Usually those with the authority to take policy decisions are members of parliament and the executive, persons who, in democracies, have obtained their authority from 'the people'. Discretion and decentralisation widen the range of actors whom we should consider as being involved in policy decision making.

One way to explore the scope of decision making at the level of implementation is to ask about the extent of discretion and how discretion is used. Davis (in Parsons, 1995:

469) states that “A public officer has discretion wherever the effective limits on his power leave him free to make a choice among possible courses of action and inaction.” Barrett (2004: 253) notes that the nature of discretionary power, meaning “scope for action in organisational settings”, is a key theme that bottom-up researchers who focused on “street-level bureaucrats” have explored. In other words, discretion allows public officials to change the policy outcomes by acting or not acting.

Lipsky drew attention to the fact that what he called “street-level bureaucrats” could alter policy goals through the way that they use their discretion. So if those at the frontline of implementation decide about implementation strategies, then they are able to take decisions that could lead to deviations from policy makers’ intentions. Furthermore, Lipsky (1980) points out that to analyse discretion in implementation means to examine what implementers do or do not do. He demonstrated that street-level bureaucrats, the people directly engaged in service delivery such as teachers and police officers, use their discretion to develop coping strategies to balance policy demands with the demands of their environment. The implication of implementers using discretionary action is that they affect the nature of service delivery through their actions.

But not all implementers are street-level bureaucrats. For example, in countries where there are multiple levels of government, it is possible that a national level of government would be considered policy makers, while sub-national levels of government would be viewed as implementers. In this case, if one was interested in policy change, one would have to direct attention to the decision and activities of the sub-national level of government and would have to assess whether these decisions and

activities lead to outcomes that deviate from national policy expectations. Furthermore, in most instances sub-national governments have elected politicians at the helm, which would mean that there are potential policy makers at the head of a sub-national level of provincial government who could also initiate policy change through their decisions.

Decentralisation offers an insight into the extent to which sub-national levels of government are given decision-making scope. Walt (1994) describes the role of process and power in a health policy research context and also describes the value of examining decentralisation, albeit indirectly, as a means to understand implementation processes. She discusses the role of sub-national institutions in the public policy process and notes that the extent of decentralisation in the government system affects the extent to which sub-national-level bodies can affect implementation and policy formulation (Walt, 1994: 92). Walt (1994) draws attention to the role of decentralisation in facilitating a link between policy-making processes and implementation processes.

Decentralisation refers in a general sense to a downward transfer of decision-making power. Decentralisation can be defined as “the assignment of fiscal, political and administrative responsibilities to lower levels of government” (2005: 1045). Galvin and Habib (2003) identify three different types of decentralisation: deconcentration, delegation and devolution. Each type of decentralisation is associated with varying levels of decision-making power. Deconcentration means “shifting power from central offices to peripheral offices of the same administrative structure” (Bossert, 1998: 147). Delegation means transferring authority to an agency over which central government still exercises control. Devolution means providing “local bodies with the authority to make decisions” (Galvin and Habib, 2003: 868). It is important, in terms of the

persuasion framework, to explore which type of decentralisation exists within the government system. This will help one to understand the extent to which sub-national levels of government have decision-making power. If implementers have decision-making space, then they are able to take decisions on implementation strategies that could lead to policy change.

### *Motivations for policy change*

If implementers had extensive decision-making scope, why would they use it to initiate policy change? As policy change is a research theme in a variety of disciplines, there are many possible motivations to explore. I therefore first offer a brief review of the motivations for policy change from international relations and the public policy studies literatures before discussing two important motivating factors in the persuasion framework, namely ideas and interests.

In international relations researchers' explanations of foreign policy change include, amongst others, domestic actors changing the norms and rules of the international system (Koslowski and Kratochwil, 1994), decision makers acting to avoid loss (Welch, 2003), policy makers' role conception (Grossman, 2005) and the role of ideas (Goldstein and Keohane, 1993).

Public policy studies researchers explore policy change as a theme through which they examine how public policy processes work generally. Some explanations for policy change include competing beliefs held by various advocacy coalitions (Sabatier and Jenkins-Smith), policy learning (Bennett and Howlett, 1992: 275) and the evolution of ideas within public policy processes (John, 1998).

I discuss two main motivating factors, ideas and interests. International relations researchers have explored, for example, ideas and interests as motivations for policy change. Goldstein and Keohane (1993) and Welch (2005) are IR researchers who have focused on the role of ideas and avoiding significant losses respectively as key motivations for policy change. Goldstein and Keohane (1993) are the editors of a book that explores the role of ideas, which refers to the beliefs held by individuals, in shaping political outcomes in foreign policy. They argue that “ideas influence policy when the principled or causal beliefs they embody provide road maps that increase actors’ clarity about goals or ends-means relationships, when they affect outcomes of strategic situations in which there is no equilibrium, and when they become embedded in political institutions” (Goldstein and Keohane, 1993: 3). Welch (2005) is interested in changes in the behaviour of states (Welch: 2005: 6). He notes that foreign policy is most likely to change dramatically when leaders expect the status quo to generate “continual painful losses” (Welch: 2005: 8). Policy change is therefore motivated by the need to avoid significant loss.

Policy process theories on policy change informed by political science tend to focus on interests. Schlager and Blomquist, (1996: 652) note that political scientists suggest that a political theory of the policy process must take into account that political actors engage in the policy process to advance their careers and their own interests. Schlager and Blomquist (1996) review Sabatier and Jenkins-Smith’s Advocacy Coalition Framework, Moe’s Structural Choice (SC) and Ostrom’s Institutional Rational Choice (IRC), three potential public policy process theories. The explanation in SC and IRC is self-interest. These frameworks direct attention to the individual interests of those who

initiate policy change. The exception here is the ACF, which focuses on beliefs and views policy change as the product of three sets of processes over time (Sabatier and Jenkins-Smith, 1993: 183). These processes are the “interaction of competing advocacy coalitions within a policy subsystem”, “changes external to the subsystem”, which provide opportunities or obstacles to competing coalitions, and the “effects of stable system parameters” (social structure, constitutional rules) on constraints and resources of the actors in the policy subsystem (Sabatier and Jenkins-Smith, 1993: 5). The ACF is criticised because of its assumptions about human nature. People are viewed as instrumentally rational in that they are not driven by goals such as economic or political self-interest (Nohrstedt, 2005: 1045).

These theories tend to focus on policy makers or those with the authority to initiate policy change. However, ideas, interests and avoiding loss are motivations that are relevant to any policy actor. Welch (2005: 22) notes that what we call interests and preferences and state behaviour is “convenient shorthand” for the goals and the choices of human beings and it is their behaviour that we observe.<sup>28</sup> In other words, implementers have ideas, interests and perceptions of their role, and they want to avoid loss. I focus on interests and ideas as motivating factors that lead to the initiation of policy change.

What does ‘interests’ mean? Welch (2005: 8) argues that foreign policy is most likely to change dramatically when leaders expect the status quo to generate continual painful

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<sup>28</sup> Hicklin and Godwin (2009: 14) in their article on the role of public managers as agents of change, similarly note that individuals rather than institutions take decisions that drive policy. Thus they note that when one focuses on the constraints on institutions, the picture of micro-level decisions will be flawed (Hicklin and Godwin, 2009: 14). This is a comment on all theories that focus on institutions without paying attention to the role of individual behaviour, because “they miss some of the critical variation generated by individual behavior within the decision-making processes” (Hicklin and Godwin, 2009: 14).

losses. He views interests as synonymous with goals and he notes that this must be articulated in policy or situation-specific terms. Nohrstedt (2005) supports the view that loss is important. He points out that in his study on policy change in nuclear energy policy that external events can cause coalition members to consider potential political loss and they will consider their options based on this (Nohrstedt, 2005: 1056). In this framework preserving interests means avoiding loss. Therefore any situation or outcome which is likely to be perceived as leading to significant and continuing losses will be treated as a reflection of interests.

An important part of establishing the role of interests in initiating policy change is to explore what implementation activities associated with the policy change produce. Mosse (2005: 103) noted that the actions taken during implementation have different functions, which could be to secure individual and organisational interests. So we have to ask whether implementers would want to maintain the organisation's ideas and its structural integrity because they are dependent on the organisation. If one finds that policy change maintains established ideas, then policy change reflects both individual and organisational interests.

The second key motivating factor is ideas. Goldstein and Keohane (1993) explore the role of ideas (beliefs held by individuals) in shaping political outcomes in foreign policy. They offer a number of ways in which to identify important ideas. Goldstein and Keohane (1993: 3) argue that "ideas influence policy when the principled or causal beliefs they embody provide road maps that increase actors' clarity about goals or ends-means relationships, when they affect outcomes of strategic situations in which there is no equilibrium, and when they become embedded in political institutions." I focus

particularly on ideas becoming institutionalised, meaning that the ideas become part of an organisation's design, which is when ideas become powerful because they can constrain change.

Goldstein and Keohane (1993: 12) note that institutionalised ideas would constrain change or, in other words, maintain stability.<sup>29</sup> The implication is that established ideas will try to prevail against policy change. However, Hinnfors (1999: 296) points out that policy change was initiated in Sweden with a decision to extensively expand public childcare. Policy change in this instance maintained stability and secured certain ideological beliefs of the governing Social Democratic Party (Hinnfors, 1999). Therefore policy change can also act to preserve or implement ideas. If ideas can be institutionalised in an organisation's design (Goldstein and Keohane, 1993), and ideas can motivate policy change in order to maintain the status quo (Hinnfors, 1999), it would be important to examine whether policy change was initiated to protect institutionalised ideas. In such circumstances established ideas could be considered a motivating factor for policy change.

A number of researchers note that ideas on their own do not lead to policy change (Nohrstedt, 2005; John, 1998; Hoberg, 1996). Goldstein and Keohane (1993: 25) state that ideas most often become politically effective when other changes occur, such as when there are changes in material interests or power relationships. Nohrstedt (2005)

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<sup>29</sup> Keeley and Scoones (2000: 1) examine why policy processes in Zimbabwe have reinforced the dominant land degradation narrative and with it a technocratic approach to management natural resources instead of adopting other frames of the problem? How can one narrative remain dominant? They argue that political contexts and interests shape policy. They demonstrate this by looking at how creating knowledge about soil erosion comprises hiding uncertainties and relies on networks between scientists, scientific institutions and sections of the state. The important point is that networks explain how certain types of knowledge become and remain dominant.

similarly highlights the importance of events in facilitating policy change. He notes that an event can lead to policy change in at least three ways. Events can act as catalysts for ideas that have been dormant by accelerating progress (Nohrstedt, 2005: 1046-1047); events can act creatively by producing and popularising new ideas (Mueller, 1991 in Nohrstedt, 2005: 1046); elite activity may provoke an event, which can then act as a catalyst for ideas that have been dormant by accelerating progress.

Brown and Stewart Jr. (in Sabatier and Jenkins-Smith, 1993: 100) apply the ACF to explain airline deregulation and argue that there should be a move from identifying conditions conducive to policy change to analysing the tactics of policy advocates.<sup>30</sup> They emphasise that there is “a strategic and dynamic relationship between core belief systems and observable conditions” (in Sabatier and Jenkins-Smith, 1993: 101). They identify an important tactic as being “interpretation of an event or exogenous condition to promote their policy preferences or discredit the policy agenda of the other coalition” (Brown and Stewart Jr. in Sabatier and Jenkins-Smith, 1993: 101). An important analytical question is thus whether there were any changes that may have directed attention to established ideas and how these changes were interpreted.

John (1998) explores policy change as a product of the influence that ideas have because of their relationship to political interests. His evolutionary theory of policy change focuses on explaining “why an idea can suddenly take hold and become implemented as a policy choice” (John, 1999: 40). He argues that policy is driven by

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<sup>30</sup> Lowry (2008) explores whether bureaucracies can change policy. He studied two instances of bureaucracies initiating policy change. Policy change meant that the parks deviated from long-standing policy traditions. Yellowstone Park called for reintroducing wolves into the park and Banff National Park focused on restricting further development of the town (Lowry, 2008: 287). He concludes that bureaucracies can change policy but only under certain conditions. The facilitating conditions were that formal external authorities intervened with substantial support from the media, public opinion and target groups (Lowry, 2008: 302).

the interaction over time between the focal points of major analytical approaches for studying policy. These points of focus are institutions, interests, economic power structures, individual self-interest and ideas. Each of these elements plays a role in driving policy. Institutions act as constraints if the actors choose this. Interests structure choices for actors, while economic power structures provide alternative choices. Individual self-interest acts as a driving force interacting with constraints, and ideas provide solutions and meanings for policy makers (John 1998: 182-183). John (1998: 187-188) asserts that the strength of his theory is that it offers a means to explain policy change: "Policies are caused by the sorting of successes and failures of ideas." A "selection mechanism" does this sorting. In his response to potential criticisms from political science of his use of evolutionary theory, he discusses five necessary conditions for an evolutionary explanation of policy change (John, 1999: 48). He notes that in politics this selection mechanism is the force of argument in policy deliberation or public opinion, and the selective benefits that interest groups or policy entrepreneurs gain for the policy being adopted (John, 1999: 48). In other words, what distinguishes whether ideas are successful or not depends on the strength of an argument and what policy actors or groups of actors gain from it.

*Persuasion and arguments: the pathway to explaining how policy change occurs*

If it has been established that implementation activities are realising alternative policy goals and the facilitating conditions and motivations for policy change exist, how does one explain how policy change occurs? John (1998: 198-199) noted in his review of the frameworks and theories on policy change that the network, interest group and institutional approaches that he reviewed were good at explaining stability rather than policy change. Furthermore, he noted that an important missing element from some of

these approaches was any explanation of a mechanism for policy change. He argued that a symbiotic relationship exists between ideas and interests and this is the basis for explaining policy change or policy stability (John, 1998: 166). He notes that if analysts can see policy formation as a dynamic process involving interaction between ideas and interests in a socio-economic and institutional context, then the analyst can develop a convincing account of policy change (1998: 194).

John (1998) identifies a mechanism that facilitates policy change. The mechanism for policy change is discussed in the language of evolutionary theory, which is the basis of John's approach. This overcomplicates a useful means to describe how policy change occurs.<sup>31</sup> John (1998: 493) notes that ideas become influential when linked to political interests. Ideas need a human agent with an interest in the idea to act for its survival. The human agent gives an idea direction and identity (John, 2003: 493). Policy change thus occurs when a policy advocate links his/her ideas and interests to the interests of policy makers. The policy maker is persuaded and takes a decision, which leads to policy change. If policy formulation can occur at the level of implementation, then it is possible to explore whether a policy advocate had attempted to convince policy makers to adopt his or her policy advice.

Argument and persuasion are two important components of the mechanism that leads to policy change. When we focus on argument and persuasion in the public policy

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<sup>31</sup> Dowding (2000: 74) criticises John for not offering a selection mechanism or even a few selection mechanisms in his theory. Dowding (2000: 74) asserts that mechanisms providing an evolutionary explanation should include a functional feature of the institution, which will lead to its survival. But the functional feature must not be a function for which the institution was designed or else the explanation is intentional instead of evolutionary (Dowding, 2000: 74). So where beneficial consequences are unplanned, an explanation may be deemed an evolutionary explanation. John responded to criticism by McConnell (2000) and Dowding (2000) with the point that scholars tend to assume influence rather than demonstrate it (John, 2000: 90, 93).

process, we direct our attention to the role of language in facilitating policy change. Majone (1989: 1) emphasised language in the opening line of his book entitled *Evidence, argument and persuasion in the policy process*, in which he noted “As politicians know only too well and social scientists too often forget, public policy is made of language. Language is malleable and can be used strategically to persuade.” I focus on how language is used to persuade those with the necessary authority to adopt policy advice that would lead to outcomes that deviate from expressed policy expectations.

The focus on argument and persuasion links this framework with the narrative turn in public policy studies. The narrative turn refers to a shift amongst some public policy researchers toward understanding aspects of policy through an interpretive approach. Fischer (2003: 49) describes an interpretive perspective as comprised of two principles: meaning is important in the construction of social reality, and social meaning can change. An interpretive orientation toward how the policy process operates directs attention to the way that discourses can initiate policy change. Fischer (2003: 74) paraphrases Meinhof’s (1993) idea of discourse as the links between sentences that add up to more than what each individual sentence would suggest. Discourse thus provides insight into the bigger picture that informs the policy activities that we attempt to understand and explain. Yanow (1987) made the same point when she argued that we should pay more attention to the policy culture within which implementation occurs.

The important question is: how can argument and persuasion contribute to understanding how policy change occurs? John (1998) argued that when ideas are linked to policy makers’ interests, then policy change occurs. How are ideas linked to

interests? The policy advocate is a central figure that facilitates policy change. As John (2000: 89) notes, the reason is that “While policy makers think they are in charge, they often articulate ideas and courses of action that are embedded in the institutions and networks of relationships they occupy.” In other words, policy advocates could be leading policy makers to take decisions that reproduce existing ideas and ways of doing.

The policy advocate thus facilitates policy change by linking his/her own ideas and interests with policy makers’ interests. We can think of the link between ideas and interests as a problem representation. In her work on the social construction of policy problems in gender policy Bacchi (1999: 1) defines a problem representation as an “explicit or implicit diagnosis of the ‘problem’.” She focuses on the implications of problem representation, one of which is that if a particular problem representation is adopted, it can prevent certain topics from being discussed (Bacchi, 1999: 3). The problem representation is important in the persuasion framework, because it would be a narrative that contains arguments defending a particular perspective of the problem and which offers a solution to the problem construction. The problem representation is thus important because it is the tool of persuasion.

A first step when explaining policy change would be to identify a policy advocate. John (2003: 493) suggests that one should consider expanding who is considered to be a policy entrepreneur to include everyone with a stake in the outcomes. Identifying a policy advocate may be a difficult task if an individual or a group cannot be specifically identified as having played this role in initiating policy change through interview material, policy documentation or other communications. If, however, there is a

reference to a policy advocate in the research material, it is still important to verify that the individual or group was indeed involved in initiating policy change. We could identify a policy advocate by comparing problem representations from interview material with the arguments from policy documentation and in policy makers' statements to both the public and the legislature or any other authority to which the policy maker would be accountable. While the policy makers are likely only to offer arguments to support their decision, the policy advocate would be able to offer a narrative that places the problem representation in its wider policy context. In other words, the policy advocate would be able to make the kind of links between different pieces of what Majone (1989) refers to as "policy space".

Another important part of explaining how policy change occurred is demonstrating that the policy advocates' problem representation was sufficiently persuasive. In other words, the policy solution that the problem representation proposes should speak to policy makers' interests. Policy makers' interests are defined as attempts, in Welch's (2005: 8) terms, to "avoid continual painful losses". One would therefore expect that any problem representation that created the impression of significant and continuous loss for the policy makers, meaning a loss of power, a loss of control over a function and a financial loss would be avoided. The policy solution that the policy advocate would provide would speak to policy makers' interests, because it would be presented as an option that avoids such significant loss. Avoiding loss would therefore mean that policy makers adopt an alternative solution that prevents them from having to experience any form of loss.

*Unpacking the politics underlying policy change*

Problem representations can also provide an insight into the politics that affects the way that implementation operates and whether policy change can occur during implementation. Bacchi (1999: 2) asserts that we should shift our focus from viewing policies as solutions to problems to seeing policies as competing representations of political issues. The problem representation directs the analytical focus to discourse, which she defines as “the language, concepts and categories employed to frame an issue” (Bacchi, 1999: 2). Bacchi (1999) argues that problem representations are important objects for study because they have effects. One of the important effects is the way that certain definitions of problems can sideline other definitions of problems and privilege certain policy solutions (Bacchi, 1999: 20). In this instance the main effect is that problem representations can facilitate policy change, because they may be used to persuade. In this case I do not treat policies as competing representations, but instead I examine the competing problem representations from various data sources to illuminate the competing perspectives. These competing perspectives will highlight the detail of the policy of implementing health reform, because it will draw out the issues that are being contested.

Understanding the politics underlying public policy implementation would require that we analyse contending problem representations. According to Bacchi (1999: 21) one finds the problem representations when one examines the policy solutions. Bacchi focuses on policy making and problem constructions. This research focuses on implementation and on competing policy solutions that exist at the level where health system reforms are meant to be implemented. As one of my research aims is to explain in detail why an implementation gap occurred, I will go beyond only identifying the

problem representations. This entails also exploring the narratives, which are the context within which the contending problem representations and policy solutions make sense.

One of the contending problem representations is likely to be adopted. The dominant problem representation should be analysed in order to understand the politics of implementation. Bacchi (1999: 39) suggests adopting a theory of power to explain which problem representations are dominant and why. She notes that the theory of power will assist with aspects such as “who becomes the problem representers, whose representations get taken up and whose voices remain unheard” (Bacchi, 1999: 39). Instead of adopting a theory of power to explain why one problem representation becomes dominant, Bacchi’s questions can be applied for this purpose. Furthermore, John’s (1998) key mechanism that facilitates policy change suggests that to understand why a particular definition of a problem is adopted, we need to examine why the problem representation was persuasive. In other words, one has to examine what the various problem representations meant in terms of policy makers’ interests.

When we focus on the politics of implementation we are unpacking what others have termed the continuation of the politics of policy making. In other words, unresolved matters that were debated as part of the policy formulation initiatives would resurface at the level of implementation. Thus if policy change occurred during implementation, then implementation may be viewed as a space where unresolved policy issues from earlier health reform policy development processes were resolved. This analysis could offer important insights into the way that issues are repackaged in order to facilitate policy change.

In summary, the persuasion framework has four main components. These components are the facilitating factors for policy change, the motivations for policy change, the explanation of policy change and the politics that provide a broader understanding of the link between implementation and policy change. Policy change occurs when a policy advocate develops a problem representation, which joins the advocate's interests and ideas with the policy maker's interests. The problem representation is persuasive because the problem construction leads policy makers to perceive a situation as one that could lead to "continuous painful losses" (Welch, 2005: 8) for policy makers. Policy makers therefore adopt the policy advocate's proposed solution to avoid experiencing significant loss.

## **2.6 Conclusion**

Much public policy implementation research has concentrated on finding solutions to a particular implementation problem, which is that implementation outcomes do not conform to policy expectations. The goal of such implementation research was twofold. The one goal was find ways to narrow the gap between policy expectations and what implementation produces. The second goal was to develop a theory on implementation which could be applied in any context. The second goal is associated with the first goal in that the aim was to eradicate implementation gaps. Over time policy implementation researchers became increasingly aware of the number of factors that they had uncovered that affect implementation, but there was still no coherent theory. This gave rise to another debate, one about whether implementation research was still useful. Within all these debates implementation gaps remained the key problem that research was meant to resolve.

What I have taken issue with in this chapter is that implementation gaps are associated with failure. I argued that the assumption that policy drives implementation is an assumption that stems from the influence of the policy stages approach and the expectations of the way that government operates in a representative democracy. Then I highlighted the view that we need to be cautious about what we refer to as implementation failure, because policy could be developed for other reasons than to guide implementation. I noted in turn that implementation could work toward other ends than putting policy into effect. Failure could therefore only be an appropriate interpretation of implementation gaps in certain instances. I argued therefore that when implementation decisions and activities realise alternative policy goals to those expressed in policy, then we should consider whether an implementation gap is not signalling policy change instead of failure.

The persuasion framework which I outlined in this chapter is a means to test whether policy change could be an alternative interpretation instead of implementation failure when one observes implementation gaps. The persuasion framework has three main elements to link what happens at the level of implementation with policy change. The first main element was that the foundation for policy change – in particular, the nature of the government system – was conducive to initiating policy change from the level of implementation. I discussed discretion and decentralisation as two different types of facilitating factors for policy change. The second element was motivations for policy change. I discussed established ideas and interests as key motivating factors. The third element is the explanation of how policy change occurs. I used John's (1998: 493) argument that ideas become powerful when they are attached to political interests. I

discussed Bacchi's (1999) concept of problem representation as the tool of persuasion. As this framework is based on an interpretive understanding of policy, I focused on the problem representations as the carriers of meaning and arguments that support a particular understanding of a problem and a policy solution. The key link that explains policy change is that a policy advocate offers the problem representation to the policy maker. Because the problem representation is intimately linked to the policy makers' interests, which is guided by the need to avoid loss, it is probable that it would be adopted.

In Chapter 3 I discuss the research design and methodological perspective that informed the fieldwork process. I pay particular attention to the competing methodological paradigms amongst those who study the public policy processes through the notion of policy change and those who study the process through stage-specific investigations. This discussion will demonstrate first how my research fits into the debate about the utility of implementation research. Second, it will highlight my position in relation to an underlying methodological debate amongst public policy scholars regarding what the purpose of public policy research should be. In the second section of the third chapter I will discuss the research design and preparations that informed my fieldwork and the decisions that my fieldwork experience led me to take. I include a discussion of the selection criteria for interviewees and how these had to be expanded during fieldwork.

## **Chapter 3: The research approach and the fieldwork process**

### **3.1 Introduction**

In this chapter I discuss the research process under three headings: the research process in its design phase, the research process in practice, and data analysis. The chapter is structured in this way for two reasons: first to demonstrate the logic that informed the research process, and second so that the divergence between the fieldwork planning and the fieldwork practice is made explicit. The changes made during fieldwork were particularly important, because these changes generated insights that would lead to an alternative explanation of the implementation gap in health system reform in the Western Cape Province.

In the first section on the research design I discuss why a case study research design was selected and I address the key criticisms of case study-based research. I describe the data-collection tools as well as the anticipated role of each of these tools in the research process. In the second part of this chapter I discuss the fieldwork process. The main themes that are discussed are the changes to the fieldwork process planning during fieldwork. I pay particular attention to changes to the nature of the interview, the way in which interviewees were identified, the changing role of observation and the types of documentation that I was able to obtain during the fieldwork process. In the final section of this chapter I discuss how I analysed the data during and after the fieldwork process. Analysing the material, particularly the interviews, during fieldwork contributed to changes in the data collection tools. This chapter concludes by summarising the main points about the pre- and post-fieldwork process. I also briefly describe the first empirical chapter, which follows this chapter.

### **3.2 The initial research design**

A research design presents the logic linking the choice of data-collection methods, the data-collection process and the data analysis with the research findings. Each component is linked, explicitly or implicitly, to a methodological orientation that affects how a researcher thinks about the nature of the research product as well as what data-collection methods and data-analysis tools would be appropriate for the research purpose. This section of the chapter presents the logic that informed the selection of the case study research design and the plans for data collection, which was done between July 2005 and September 2005.

#### *Why conduct a case study?*

From the time of Pressman and Wildavsky's research in the 1970s on the implementation of a federal government minority employment policy in Oakland, case studies have remained the main means for studying implementation. However, some public policy implementation researchers question the use of case studies, because it does not achieve the research goals that some aspire to. For example, Goggin (1986) notes that case studies have produced lists of factors that affect implementation, but nothing in the way of theory.

When we use a case study research design to explore an implementation gap, we study a phenomenon in its context. This emphasis on context is reflected in various definitions of the case study. For example, Ragin (1992: 2, 5) defines case studies as "an analysis of social phenomena specific to time and place." Stake (2003: 48) notes that a case study is "not a methodological choice, but a choice of what is to be studied"

and as a form of research it is defined by an “interest in individual cases”. Yin (2003: 12-13) defines a case study as a design for investigating “a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.” The case study, as a research design, thus directs specific attention to a phenomenon that is contextually bounded. I therefore understand case study research design as a plan that facilitates studying a case within its context, where the context refers to the time and place where the phenomenon occurred.

The debate about whether implementation research is still valuable is worrisome because it suggests that case-based research, which aims to unpack and document implementation processes, is no longer useful for understanding implementation. However, one should ask whether those who argue for generalisable theory rather than case-based research have considered that significant insights on implementation could be lost if one does not examine, for example, the relationship between the operational practice of a government system and implementation outcomes. Schofield (2001: 246) supports case study research when she points out that much policy research is conducted by Americans, Europeans and Scandinavians. The policy processes that these researchers study reflect national differences and thus she argues it is impossible to recommend “global modes of policy implementation” (Schofield, 2001: 246). A more concrete example of this point is Sabatier and Jenkins-Smith’s Advocacy Coalition Framework. This is an important framework that forms part of the endeavour to develop public policy processes theory. However, some researchers have questioned its broader applicability because of the pluralist assumptions underlying the framework. Mawhinney (in Sabatier and Jenkins-Smith, 1993: 59) noted that the framework needs to be tested outside of the United States and outside regulatory policy arenas. Fischer

(2003: 99) and John (1998: 173) similarly point out that the group context, which comprises a variety of policy actors within and outside of government, may not be as applicable outside of the United States.

My research aim is twofold. First, I seek to offer a means to understand health system reform in South Africa. Second, I aim to contribute to our understanding of how implementation processes work. Yin (2003: 6) describes the case study as a means to conduct an in-depth analysis, because it assists in dealing with “operational links needing to be traced over time, rather than mere frequencies or incidence.” The important point here is being able to trace links over time, because tracking and understanding policy change requires a research design that can facilitate developing a longer-term perspective. This longer-term perspective is particularly valuable for examining how debates are expressed during implementation.

Furthermore, the main focus of this research project was to understand the implementation gap that existed in the Western Cape Province. Logic suggested that fieldwork should focus on what happened after the decision to transfer primary health care services was made. This meant that in terms of time the focus of data collection would be on developments after October 2001, when the PGWC had indicated that they wanted to transfer primary health care services to the City of Cape Town municipality. Before proceeding to fieldwork I was aware of the Health Services Task Team’s investigation on how to implement an intergovernmental transfer of service delivery. Based on the initial investigations of the literature, this task team’s work was the only activity that occurred after the decision was taken. At the time of planning the fieldwork I was only clear on the date from which the investigation of the lack of

implementation would begin, which was October 2001. The fieldwork began in September 2005 and ended in April 2006.

*Problems associated with a case study research design*

Methodological orientation has important framing effects for how researchers perceive the case study. Fischer (2003) notes that a researcher with a positivist orientation tends to treat a case study as a research method rather than a research design. Fischer (2003: 4) describes the positivist orientation as emphasising “rigorous quantitative analysis, the objective separation of facts and values, and the search for generalizable findings whose validity would be independent of the particular social context from which they were drawn.” The case study is thus treated largely as a method and one that supplements the primary quantitative research method. When a case study is treated wholly qualitatively, however, it entails a primary decision about the nature of the research design, with the main choice of research methods falling from within the range of qualitative research methods available. In other words, whether a case study is treated as a research design issue or a research method issue is contingent upon the methodological lenses of the researcher.

Methodological lenses also inform the way that researchers judge the quality of the research. I have discussed how perceptions of the research purpose shape the way that public policy researchers perceive the role of research. It is important to discuss the relationship between the methodological underpinnings of research and the criteria used to critique research designs. This discussion is important because it highlights that applying the dominant research paradigm’s criteria for quality research can lead to inappropriate criticisms. For example, one of the criticisms of the case study is that it

lacks rigour (Yin, 2003: 10). Baxter and Eyles (1997: 506) define rigour as “a process of critical appraisal to determine whether or not a study is worthy of attention.” Baxter and Eyles (1997: 506) note further that qualitative research has taken on the conventional criteria associated with rigour, namely validity, reliability and objectivity. One of the focus points of the evaluation is “plausibility of the research design”, which focuses on aspects such as the methodology, methods and analysis (Baxter and Eyles, 1997: 506). These conventional criteria are associated with a positivist orientation.

Additional criticisms of case-based research include the issue of generalisability (Yin, 2003: 10), otherwise referred to as external validity. The issues regarding generalisability are associated with a positivist methodological orientation. Yin (2003: 10; 37) notes that “analytic generalization” is more appropriate in the context of case studies where generalisations are made to “theoretical propositions and not to populations or universes.” While the key aim of this research is not generalisation, this research does offers insight into how to interpret observations on public policy implementation, and other researchers may choose to examine whether implementation gaps are signals of policy change in other contexts.

Yin (2003: 10) points out that a case study does not necessarily require long periods of time for data collection. This, Yin notes, may be a misconception arising from confusing the case study with participant observation: as a data-collection method or as ethnography in the vein of a qualitative research tradition (Yin, 2003: 10). Yin (2003: 12) notes further that case study research produces large amounts of data and that this is an appropriate complaint. Once again it is appropriate to note that the case study as a research design is meant to facilitate in-depth understanding of a particular

phenomenon and this would include extensive time for data collection. Furthermore, the amount of data would also be appropriate to the research purpose as the researcher tries to understand the phenomenon within context. This is in contrast to research where the focus is, for example, on establishing whether there is a set of factors that affects implementation in a number of contexts.

Winter (2000), Yin (2003) and Mishler (1990) have noted that the criticisms which stem from a different methodological perspective to the one which informs the research would be misdirected. Thus evaluating research based on a case study research design, where the purpose is to provide in-depth and contextualised understanding, by applying positivist criteria for good research would not be appropriate, especially if an interpretive methodological orientation informs the case study.

Interpretive-orientated researchers such as Mishler (1990) proposed trustworthiness as an alternative criterion for judging the quality of research informed by an interpretive methodological orientation. Trustworthiness then stands in contrast to validity and reliability, criteria which are based on assumptions about the world that are not relevant to the interpretive orientation.

What then would make a case study informed by an interpretive orientation trustworthy? If the larger goal is to produce research that enlightens a reader about public policy implementation processes, then it is logical that they would need to trust the process that produced the research product. Mishler (1990: 415) proposes an “exemplar” as the basis for establishing trust in research. The exemplar is a research journal which contains an account of the data-collection decisions and strategies as they

develop within the field. Mishler (1990: 422) highlights why an exemplar is important when he asserts that “Skilled research is a craft” and that in hiding their skills scientists “reaffirm the ‘objectivity’ of their findings and reproduce the assumptive frameworks of ‘normal science’.” He argues that exemplars hold the means, criteria and procedures to evaluate trustworthiness and “serve as testaments to the internal history of validation within particular domains of enquiry” (Mishler, 1990: 422). Mishler (1990) has influenced the way I have presented this chapter on research methods. The discussions on research planning, the fieldwork processes and the post-fieldwork reflections should thus be seen as a basis for judging whether the research is trustworthy.

#### *Planned data-collection methods*

Yin (2003) notes that the advantage of a case study as research design is that it is not linked to a particular research method. A researcher is thus able to use a range of data-collection methods. Fontana and Frey (2003), who offer an overview of the changing perspectives on interviewing, note why using multiple data-collection methods is valuable. They note that “Human beings are complex, and their lives are ever changing; the more methods we use to study them, the better our chances are to gain some understanding of how they construct their lives and the stories they tell us about them” (Fontana and Frey, 2003: 99). Each of the data-collection methods used in this research project should be considered in terms of this perspective.

Because a case study research design is associated with qualitative research and an in-depth examination of a phenomenon in its context, some research methods would be deemed more applicable than others. For example, it is less likely that a researcher would adopt a research tool that produces statistical data when the primary research

design is a case study. The main reason is that research that focuses on collecting statistical data and research that is case-based differ in terms of their research focus. Statistical analysis focuses on data that can facilitate identifying trends that may form part of a generalisable theory about a particular phenomenon. A case-based analysis, however, seeks a depth of understanding of a particular phenomenon as it manifests in the context of study.

In this research project I collected data through observation, interviews and documentation analysis. Arskey and Knight (1999: 14-15) note that it is important to consider whether the research methods used for the study are appropriate to the research purpose. In the discussions of the various data-collection tools below I demonstrate the logic that informed the selection of the data-collection tools for this study.

Arskey and Knight (1999: 7) discuss three approaches to interviewing: structured, semi-structured or unstructured. They note that the semi-structured approach is most commonly used and they describe such as an approach and entailing a situation where the researcher has an agenda and has certain topics or themes to focus on, but the process is open to questions for clarification, probing or further explanation (Arskey and Knight, 1999: 7). A benefit associated with a semi-structured interview is that there is clear guidance for the researcher on where to go once a question has been addressed.

There are, however, also problems with interviews. Interviewees can attempt to present interviewers with what they think the interviewer would like to hear. Because of this potential problem it is important that interviews are not the only method employed to

explore a phenomenon. Thus this project also relies on insights from observation and document analysis to unpack why the transfer of health services did not happen. The benefit of using a number of data-collection tools is that it enables triangulation. Neuman (2000: 125) notes that for social research triangulation means “it is better to look at something from several angles than to look at it in only one way.” By using various methods of data collection, one could examine claims made in interviews with insights from documentation.

The initial interview schedule, as well as those developed during the fieldwork process, were semi-structured. I selected a semi-structured interview schedule because I needed a tool that would guide my line of questioning and facilitate exploring issues emanating from the interviews. The interview schedule was constructed around a central question for investigation: why were primary health care services not transferred from the PGWC to the City of Cape Town municipality after 2001? This question directed attention to the factors that may have produced the implementation gap. The initial readings for the research outline, in particular the CHSO Annual report (2003), led me to think that the interview schedule should also explore the nature of interdepartmental and intergovernmental relations. The annual report referred to City Health, the PGWC’s Department of Health and the PGWC Treasury as part of the problem that led to the stalled implementation of the transfer. This raised questions about what undermined the transfer process. Were interdepartmental issues between the PGWC’s Department of Health and the PGWC Treasury indicative of disagreement about the transfer of health services and did this lead to the lack of implementation? Did implementation not take place because of intergovernmental issues between the

provincial Departments of Health and the Treasury, and City Health, the City of Cape Town municipality's health department?

The CHSO annual report (2003) also refers to a negotiation process undertaken for a service-level agreement between the Western Cape Department of Health and City Health. The service-level agreement is a contract between these two bodies and was meant to structure the relationship between the two parties by outlining the respective responsibilities of City Health and the Western Cape Department of Health. I thought that the interview schedule should contain a question about the negotiations for a service-level agreement, as this could enhance my understanding of some of the intergovernmental issues.

Another reason for selecting semi-structured interviews was that even though I had some theoretical and practical training in interviewing, I did not feel comfortable conducting an unstructured interview. It was important for me to have an interview schedule to avoid creating the perception in an interviewee that I was unprepared. It was important that interviewees perceived me to be serious about my research, as the interviewees were also my main source for further prospective interviewees.

During the planning phase of this project interviews were viewed as tools that would help ascertain the factors that could explain why an implementation gap arose. The main influence for this way of thinking was that the factors leading to implementation gaps were a prominent focus in public policy implementation research. This way of thinking about the interviews reflects a positivist orientation. I expected that the interview material could highlight the factors that would explain the implementation

gap in this context. Silverman (2003: 343) refers to this as a “*realist* approach to interviewing”, which is based on the assumption that the interviews “index some external reality”.

During the planning phase for this research project I identified potential interviewees based on the CHSO annual report explanations of why implementation did not proceed. I anticipated that managers in the CHSO would be able to provide an insight into why primary health care services were not transferred to the City of Cape Town municipality. Furthermore, as the report had indicated that implementation stalled as a result of a conflict between the provincial treasury, the provincial health department and the City of Cape Town health department (CHSO, 2003: 8), I expected that the CHSO managers would know who was involved in negotiating the terms for the transfer. My initial plan was to find more interviewees during the research process by asking current interviewees to refer me to other people who were involved in these processes.

Observation was another data-collection tool used in the fieldwork process. Denzin and Lincoln (2003: 48), in their introduction to observational methods of collecting and analysing empirical materials, note that “going into a social situation and looking is another important way of gathering materials about the social world.” Observation was considered as a research method in this project because it was a means to gain access to the Community Health Services Organisation (CHSO), which is the provincial health department agency that provides public health services in the geographical territory constituting the metropolitan municipal area. I anticipated that my presence and interaction would facilitate obtaining information and direction for further interviews

during fieldwork. Second, I hoped that my presence in the organisation would also lead to developing rapport with management staff, as this would mean that I could obtain a better understanding of how public health system transformation was unfolding within the Western Cape Province and specifically in the metropolitan municipal area.

Acquiring relevant documentation was another key form of data collection in this research project. Documentation here refers to written texts. Denzin and Lincoln (2003: 50) refer to written text and cultural artefacts as “mute evidence” as there is no verbal communication between the researcher and the material. Such data were considered useful for identifying why implementation did not occur.

The criteria for selecting relevant documentation were, first, that the documents referred to the policy decision to transfer. Second, I sought documents that discussed the process of health system reform, in particular DHS implementation, after 2001 in the Western Cape Province. Other documents that were considered important were those that identified activities associated with health system reform in the Western Cape Province. During the planning phase for fieldwork I was not sure about the kinds of documentation that would be accessible. However, based on a pre-fieldwork search I identified some potentially informative documents such as the District Health plans and District Human Resources plans as well as provincial government strategic planning documents for health in the Western Cape Province.

I began this research with little practical knowledge about how the public health system operated in post-apartheid South Africa. When planning the research process my main source of information about the public health system in the Western Cape Province and

in South Africa was research reports and studies dealing with specific public health sector reforms before and after 2001. I planned to find prospective interviewees via documentation accessed during the initial stage of fieldwork and by asking interviewees to refer to me other persons who were involved in health system reform during the time period identified for this research.

The Community Health Services Organisation was viewed as the starting point for data collection for two reasons. First, it was its 2002-2003 annual report that led me to the phenomenon of an implementation gap. The CHSO indicated that if the decision to transfer primary health care services had been implemented, these services would have been transferred to the City of Cape Town municipality (CHSO, 2003: 7). Furthermore, the annual report highlighted problems at a political level as well as inter-departmental problems as key factors that affected implementation (CHSO, 2003: 18). I anticipated that the managers in this organisation, who had written the report, would be able to provide some insights into what happened with DHS implementation in the Western Cape Province after 2001. It was therefore anticipated that the CHSO managers would provide further prospective interviewees, in particular those persons who had been involved with health system reforms during and after 2001.

In summary, the data-collection methods – namely semi-structured interviews, observation and document acquisition – were all meant to serve as a basis for ascertaining the factors that affected implementation. At the same time the findings from one data-collection tool were meant to serve as a check on the findings from another data-collection tool. Approaching research in this way, with a view to finding a single answer, indicates that during the planning phase I approached data collection

through a positivist lens. The emphasis was on finding a precise answer to the problem of the presence of an implementation gap in the health system reform process. The data analysis discussion as well as the presentation and interpretation of the findings in later chapters will highlight the influence of an interpretive orientation.

### **3.3 From planning to practice: the fieldwork process**

In this section of the chapter I describe how the fieldwork process diverged from the research plans. There are two important themes: changes to the interview structure and sourcing of interviewees. The discussions of the changes during the fieldwork are interspersed with commentary on the need for, and the value of, these changes. In particular, many of the changes contributed significantly to my understanding of both the health policy implementation context in the Western Cape Province and of the obscuring effects of the conceptual approach to studying implementation processes at the time.

During most of the fieldwork period from September 2005 until the end of April 2006 I wrote monthly reports to my supervisors. At the time these reports were valuable opportunities for reflection on my fieldwork plans in relation to what the fieldwork practice was highlighting as more important themes to explore. I drew on these fieldwork reports to present the practical fieldwork considerations and the effects that this had in terms of data collection. The reports highlight what I thought were important insights about DHS development in the Western Cape Province. These insights were based on initial analyses of the interview material from interviews conducted at the time. My supervisors responded to the fieldwork reports. Their engagement and the

points that I had raised significantly enhanced my readiness to take decisions during fieldwork which could lead me along paths where I was not sure of the destination.

#### *Changes in interview plans*

I began the fieldwork process with two unstructured interviews that centred on the question of how the DHS had developed in the Western Cape Province after 2001. I decided not to use the interview schedules because the officials were not part of the group of interviewees that I had anticipated I would be interviewing. The questions on the original interview schedule therefore seemed irrelevant as neither of these officials were in the organisation where I initially sought interviewees.

I identified the interviewees in a variety of ways. Interviewees were identified through provincial government planning reports and through health management meeting minutes. I also found other potential interviewees through recommendations from other interviewees. Additional interviewees were often proposed because I made a point of asking interviewees whether they knew of anyone else who was involved in these processes. In other instance interviewees referred me to other persons who they thought could provide better insight into some aspects of the process. While on fieldwork I conducted a search for newspaper articles on health system reform in the Western Cape Province. I also identified potential interviewees from these newspaper articles.

The first two interviews that I conducted turned out to make the most important contribution to the research. First, both interviewees had been involved in the process of health system reform in the Western Cape Province for at least five years. They therefore offered accounts of activities undertaken to create a district health system

prior to the Provincial Cabinet decision in 2001. Second, both interviewees provided insight into the status of DHS development at the time of the interview and they also provided a historical perspective as they could also describe the logic that led to these decisions. My initial analysis of these early interviews highlighted the fact that there were contending positions regarding DHS development. Further reflection on the initial interviews led to a shift in my research focus from investigating only what had stalled the implementation of the transfer to include what had actually happened regarding DHS development after 2001. Both interviewees had directed me to other senior-level persons who had been involved in the post-2001 activities for DHS development.

The transfer of primary health care services from the PGWC Department of Health to the City of Cape municipality would have been an intergovernmental transfer of a health service function. Therefore I still intended to conduct interviews with provincial and municipality health managers who were involved with primary health care service delivery.

However, I soon discovered that if I only conducted interviews with the two sets of health managers on why the transfer did not happen, I would have had at most twenty interviews. By 2003 the CHSO had become the Metropole District Health Services (MDHS). This organisational change meant that most of the managers were new and had not been involved in earlier health system reform processes at that level. In MDHS there were at most six managers, including the director. City Health had ten managers, of which eight were health sub-district managers, one senior health manager and the executive director.

It was important to speak to these managers, because while most CHSO and City Health managers would know little about earlier processes, they knew a good deal about what was happening at that time. I proceeded to arrange interviews with as many of these managers as possible, reflecting that my research interest had extended to post-2001 developments for implementing a DHS. I used the earlier interview schedule with adjustments to include questions exploring developments after 2001.

I asked all interviewees to provide names of people who were involved in the earlier process of implementing DHS and who were involved at that point in time. The number of interviewees increased. In total I conducted forty-one interviews during the period of fieldwork from September 2005 to the beginning of April 2006. The informants were from different organisations that contributed to DHS development. I interviewed public health managers in the PGWC and the City of Cape Town (COCT) municipality and the national Department of Health, a senior official in the National Treasury, academics from the Universities of Cape Town and the Western Cape (UCT and UWC) who were involved in earlier processes of health system reform in the Western Cape Province (UCT and UWC), a researcher from a non-governmental organisation (Health Systems Trust), officials in municipalities in the Western Cape Province, representatives of municipality trade unions (IMATU), management representatives from the Community Health Forum as well as nurses in two community health centres in the metropolitan municipal area in the Western Cape Province.<sup>32</sup>

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<sup>32</sup> The Community Health Forum is a management body of community health committees. The committees are volunteer-based, citizen oversight structures who watch over health service delivery in their respective communities. They also interact with the officials from the provincial Department of Health and officials from City Health.

Initially I sought to explore how functional integration was taking place, because this is a key theme associated with DHS development. Functional integration refers to the national health policy maker's expectation that provincial governments and municipalities integrate their health services in a way that creates regular contact between these health service agencies and contributes to realising national policy goals such as decreasing fragmentation within the public health services (National Department of Health, 2003: 2-3). When I expressed my interest in understanding how functional integration is being implemented, one of the interviewees recommended I interview nurses at community health centres. This took me to the frontline of service delivery.<sup>33</sup>

The original interview schedules were not suited to exploring DHS development from a service delivery perspective. I developed a new set of questions to explore the DHS development-related activities at the level of service delivery. The interview schedule centred on one key theme: how were primary health care services being integrated? I learnt valuable lessons about the complications associated with translating the service delivery vision associated with a primary health care approach and a DHS into practice. Conducting interviews and observing how these community health centres work enhanced my research, because my understanding of the issues affecting health system reform, particularly the problems around integrating primary health services, was expanded. Furthermore, this was useful because the process helped me understand what functional integration was meant to achieve in service delivery terms and provided an insight into the nature of the relationship between provincial government and municipal personnel at these facilities.

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<sup>33</sup> I obtained permission from both a provincial and a municipal health manager to conduct interviews with nursing staff at two community health centres in the metropolitan municipal area. The permission obtained was verbal, not written.

In summary, my experiences during fieldwork, particularly my early engagement with the material and my supervisors' responses, led to numerous changes that I had not anticipated during the planning stage. My main research focus was always DHS development. Initially the focus was narrow and centred on functional integration and the relationship between the Provincial Treasury and the provincial Department of Health. The latter was investigated as a possible key factor in ascertaining why the transfer of primary health care services to the City of Cape Town municipality had not occurred. During fieldwork the research focus expanded to include an exploration of what happened with DHS development after 2001. Particular attention was paid to an important intergovernmental relationship, the one between the Department of Health (PGWC) and City Health (COCT), which was an important part of the health system reform context.

The changes that occurred during the fieldwork process enhanced the value of my research into health system reform in the Western Cape Province. If I had followed the initial planning closely during fieldwork, my understanding of DHS development would have been seriously limited. The key theoretical insights that I elaborate on in the remainder of this dissertation are a testimony to the need to 'think in' some flexibility when planning fieldwork.

#### *Observation sites and insights*

Observation had multiple functions in this research project during fieldwork process. First I thought it would be useful to learn about the operation of MDHS when I went to conduct the interviews. This was difficult as their offices were housed in a functioning

hospital in Woodstock. Woodstock is an area just outside of the central business district of the City of Cape Town. As the MDHS was housed in a functioning hospital, this meant that patients were moving around in certain areas of the building and other parts of the building were access controlled. Most of the health managers were clustered in the section of the building that was access controlled. I was allowed access to the MDHS offices on the basis of appointments with managers. There was no communal space where people met and thus it was difficult to identify a point where I could interact with a wider grouping of MDHS staff.

Second, I could explore the relationship between the two primary health service delivery agencies that are also important structures in DHS development, namely the MDHS and City Health. It was important to examine the nature of the relationship between these agencies as the anticipated health system reforms, in particular the expectations around governance of the DHS, would change the relationship between MDHS and City Health managers. If the 2001 Provincial Cabinet decision had been implemented, then MDHS, in its previous incarnation, the CHSO, would have become the responsibility of City Health. Furthermore, the integration of CHSO into City Health would have realised another key health system reform goal, namely functional integration. So by noting the interaction between the managers from these two agencies I was able, on a basic level, to develop an impression of the context within which DHS implementation was occurring.

The relationship between these two agencies was explored on two levels, the management level and the service delivery level. Two groups of managers from these two organisations met every month. The meetings were held alternately at the MDHS

offices in Woodstock and the City Health offices in the central business district offices of the City of Cape Town municipality. These meetings focused on technical and operational matters of health service delivery within the community health centres and the clinics in the metropolitan municipal area. I was able to attend only two of these meetings as I had entered the fieldwork stage close to the end of the year and one meeting that I was meant to attend had been postponed.

At the service delivery level I paid particular attention to how the nurses from the two organisations, who worked in one community health centre, operated. My ability to observe relationships was limited to the times when I was sitting in the reception areas waiting to conduct interviews. The interviews were more useful in clarifying the situation regarding the relationship between staff who work for different agencies. The interview material informed my observations by directing my attention to arrangements within the social spaces in these community health centres and the physical location of the nurses from the two agencies within the community health centre.

Being present in the community health centres was particularly valuable for my own understanding of the ideas that guide health system transformation from a national policy perspective. I was led to think about the racial politics associated with not only the location of a community health care centre, but also the implications that this could have for service delivery. Because I am a resident of the region where I was doing research, driving to the community health centres and sitting in the reception areas heightened my sensitivity to how language could become a means to belittle 'the other'. 'Other' in this case was not only a racial other but foreigners whom I had seen in the reception areas. These were important insights about the context of health system

reform and in particular the experience indicated that community health centres may represent more than only an integration of primary health care services provided by two government agencies operating at two different spheres of government. Instead community health centres should be considered as sites where inter-racial contact was occurring between groups who each hold deeply divisive stereotypes about the other. These stereotypes were shaped by the apartheid government's categorisation of race in hierarchical terms. Therefore particular perceptions of importance were tied into a socially constructed racial hierarchy. These perceptions of importance or of the denial of privilege, depending on the racial grouping, remain and they may make community health centres a space of struggle.

#### *Documentation*

During my first set of interviews with some of the public health managers I obtained annual reports for the MDHS as well as meeting minutes for the joint management meetings between MDHS and City Health. These minutes were useful only in providing an insight into operational issues at the community health centres and in terms of the projects that the two agencies were undertaking jointly. There was other documentation, such as the strategic plans for providing public health services, which offered insights into the plans for changes to the health system operation in the metropolitan municipal area. Other provincial government plans, in particular Healthcare 2010, the provincial Department of Health's policy vision for changing the nature of health service delivery, provided useful information about what the provincial department envisioned in practical terms. The nature of the vision is discussed in further detail in the next chapter, as it relates to an important finding in this research.

I asked interviewees about documentation that they mentioned during the interviews that related to DHS development after 2001. I obtained much valuable documentation that was not in the public domain. These include documents related to the planning process that occurred after the decision to transfer primary health care services had been made in 2001. They indicated that there had been some activity around planning, which was a first step toward implementation. The documents also provided information about the key actors in these planning phases.

The most valuable documentation outlined the processes of DHS development after the planning committee for the transfer, i.e. the Health Services Task Team, had ceased to exist. The exact time at which this happened is not clear. The document suggests that the task team ended its work sometime in 2002. The important point about these later documents is that they made it clear that the research project should also direct attention to the area outside of the metropolitan municipal area in the Western Cape Province.

These documents were valuable to the research project because they allowed me to unpack the debates between actors from two spheres of government. Furthermore, they made it clear to me that focusing on developments in the public health sector alone would limit the extent to which an in-depth account of DHS development could be given. In particular, the documents directed my attention to the fact that the policy subsystem was not open to those outside of government and that I would have to pay attention to inter-sectoral activities.<sup>34</sup> This led me to search for further documentation

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<sup>34</sup> Howlett and Ramesh (2003: 53) describe a policy subsystem as a subset of actors that are involved in the policy process in a particular policy area. These subsystems may include government actors as well as non-government actors.

outside the provincial public health sector that referred to DHS development and primary health care services.

#### *Data processing*

I recorded all interviews on a micro-cassette recorder, except for one interview. I discovered the mistake immediately after the interview. I corrected the mistake by immediately noting down information from the interview. I then sent an explanation and the document to the interviewee, who confirmed and corrected some of the information. By the end of the fieldwork process I had transcribed a few of the initial recorded interviews. I transcribed the majority of the interviews during the first four months after my return from fieldwork. Each transcription was printed to facilitate the analysis. Data analysis initially focused on key themes from the interview material and addressed the question of why the transfer had not occurred.

### **3.4 Data analysis**

I began analysing the interviews that I was able to transcribe while doing the fieldwork. The analysis centred on identifying key factors that would explain why implementation had not occurred. However, I did not focus on frontline service delivery agents' use of their discretion or their interpretation of policy. Instead I analysed the material to identify important decisions and activities associated with implementing a DHS. Furthermore, I sought to ascertain how the Western Cape Department of Health and City Health public health managers understood why the transfer decision was not implemented. The interpretive orientation, which later informed my analysis, directed my attention away from the factors that produced an implementation gap and toward the narrative embedded in the interviews. The narratives tell a story about the

implementation gap and about health system reform more generally in the Western Cape Province.

The main analytical framework developed through this project was described in Chapter 2. Bacchi's (1999) notion of a "problem representation" is a central concept; it implies that defining a problem in a particular way sidelines or obscures other definitions of the problem and other solutions. Policy is analysed through narratives, which contain a logic that explains why an issue is a problem and how a problem should be addressed. The important aspect about the narrative is that "policy stories are tools of political strategy. Such linguistic constructions are designed and introduced to convince an audience of the necessity of a political or policy action" (Fischer, 2003: 169).

Problem representations are more commonly explored when researchers study agenda-setting processes. Agenda setting refers to the way that policy makers recognise that a policy problem requires government action (Howlett and Ramesh, 2003: 121). When examining agenda setting through an interpretive lens, a researcher would be examining the way that a problem representation becomes dominant and drives policy makers' selection of policy solutions. In this dissertation problem representations are used to piece together the story of the implementation of health system reform in the Western Cape Province. Fischer (2003: 161) supports extending the use of narrative analysis when he notes that "the focus on narrative analysis of stories should not be confined to the study of problem definition. It has an important role to play in the analysis of the policy cycle as a whole, in particular implementation and evaluation." This dissertation therefore contributes to the public policy implementation literature by

demonstrating the utility of an analytical tool that would usually be associated with agenda-setting research.

### *Ethical issues*

In order to avoid negative consequences for anyone who participated in this research, I sought permission from the appropriate authorities when conducting interviews, if this was deemed necessary. I did so when I wanted to interview the nurses at the community health centres. I had permission from a senior health manager in the Metropole District Health Services and in City Health respectively to interview nurses in two health facilities. I asked for permission verbally from the City Health manager and an MDHS manager sent me to two health facilities with permission that I may speak to the nurses. The nurses at the health facilities did not ask for documentation from senior managers before the interviews were conducted.

Furthermore, I had asked each interviewee about whether they preferred to remain anonymous or have their names used in the research. A number of interviewees noted in the interviews that their names could be used. As the issue under review in this research was very contentious and as some interviewees are still employed by the same agency that they had been working for when the interviews were conducted, I chose to keep the identity of all interviewees confidential. I refer to interviewees in this dissertation by their level of employment, or their rank within the organisation, and by the organisation in which they are employed. I have tried as far as possible to keep the references to these actors' identity as vague as possible.

During the fieldwork process I was privileged to have access to documentation that

outlines the health system reform processes in the Western Cape Province after 2003. These documents provided significant information and their contribution to understanding health system reform in the Western Cape Province was immeasurable. These documents include communications between important actors in the health system reform process that followed some two years after the initial decision to transfer PHC services to the City of Cape Town municipality. The provider of the documents had offered access to these documents for research purposes. I have no reason to question the validity of the documents as they are date stamped and some have government record numbers. Furthermore, the content of these documents shed light on issues that were raised in public documents such as government annual reports. I will keep these documents for five years if there are requests to view the documentation for academic purposes. The five-year period began after the fieldwork was completed.

### **3.5 Conclusion**

This chapter presented the planning logic that preceded fieldwork and the changes that were made during the fieldwork process. The aim was to provide a discussion that draws attention to the importance of flexibility in carrying out planned research, but also to allow any reader to follow the logic that led to the changes made during the fieldwork processes. Initial analysis of earlier interviews during the fieldwork process prompted the need for changes to interview questions as well as for extending the focus to actors who were outside of the geographical area to which the case applied.

I indicated that prior to fieldwork I was unsure about exactly who the interviewees would be, but I had planned to find interviewees by asking for referrals. I learnt from the fieldwork process that only a small number of people were involved in health

system reform after 2001 and had been involved with the initial work of planning for implementing the transfer. I adjusted the plan to include interviews with a range of people who were involved in post-2001 health system reforms in order to learn what activities were being undertaken at the time of fieldwork. This had important benefits for the research. By focusing on a more diverse group of persons who were involved in health system reform at various levels, I learnt about the complexities related to health system reform over a period of time.

Case studies are usually not associated with producing findings that could be applied beyond the boundaries of the context in which the research was conducted. This research does not seek to provide generalisable findings, as the methodological orientation adopted does not value this as the major criterion to evaluate research. Instead, the research product is meant to highlight the importance of the interplay between context and phenomenon when trying to understand public policy implementation. Moreover, it has sought to draw on an alternative lens for thinking about implementation, which can lead additional interpretations of implementation in practice.

In the next two chapters I describe extensively the decisions and activities that unfolded after the 2001 decision to transfer primary health care services to the City of Cape Town municipality. I draw on the various materials collected during fieldwork and offer a timeline-based description of the activities that comprised health system reform between 2001 and April 2007, which is when I ended my fieldwork in South Africa. The description is divided into two chapters, because this facilitates the presentation of a key research finding in a more direct manner. In Chapter 6 I present the interpretation

of the findings in relation to our understanding of public policy implementation processes.

## **Chapter 4: Implementation activities for District Health System (DHS) development in the metropolitan municipal area of the Western Cape Province**

### **4.1 Introduction**

The empirical material is presented in two chapters, Chapters 4 and 5. Each chapter highlights different but significant aspects of the approach to health system reform in the Western Cape Province. This contrasting picture will assist in drawing out the significant finding from this research project, which is that the policy intention regarding the direction of the transfer of primary health care services within the Western Cape Province had changed during the implementation of health sector reform. As described in Chapter 1, the national policy intention was to develop a municipality-based DHS in which primary health care services would be decentralised through a transfer to municipalities. Chapters 4 and 5 present the empirical findings on the implementation of these reforms in the Western Cape Province. They show that the provincial policy position regarding DHS implementation changed from an intention to decentralise to centralising personal primary health care services, with the PGWC taking over these services from the municipalities in the Western Cape Province.

These significant health system reform activities were relevant in a certain geographical and political jurisdiction in the Western Cape Province. The discussion of what happened to DHS implementation in the Western Cape Province has therefore been divided along geographical and political jurisdictional lines. In Chapter 4 I report on developments in the metropolitan municipal area of the Western Cape Province. In Chapter 5 I describe the decisions and activities in the non-metropolitan municipal area. In addition, there were significant policy decisions that were relevant to the whole

province, but they were applied only in, for example, the non-metropolitan area of the Western Cape Province. I have included a discussion of these policy decisions in the respective chapters.

In this chapter I describe the decisions and activities associated with the District Health System in the metropolitan municipal area of the Western Cape Province between 2001 and 2006. The first important theme is functional integration. The discussion contrasts the problem for which functional integration is the solution, namely health service delivery fragmentation, with a description of initiatives aimed at integrating primary health care services within health facilities. Following this is a description of what had been done to integrate primary health care management.

The second theme is an important provincial policy decision, namely the Provincial Cabinet's 2001 decision to transfer primary health care services to the City of Cape Town. I describe the activities that followed from this decision, highlighting the extent to which this policy decision was implemented. I then look at some insights from key health policy actors in the Western Cape Province, which offer various lenses through which the extent of implementation may be understood. These insights are examined critically in the analytical chapters that follow after chapter 5, where I use the persuasion framework, which I discussed in Chapter 2, to analyse the documents and the interview material that I collected during fieldwork.

The third theme is another significant PGWC health policy decision, which is the adoption of Healthcare 2010 as the new strategy for health service delivery throughout the Western Cape Province. This section includes a discussion of the key tenets of

Healthcare 2010, the reasons offered to explain why Healthcare 2010 was developed and the activities undertaken to implement this provincial health policy in the metropolitan municipal area.

The final theme is a policy decision to ‘provincialise’ personal primary health care services. I discuss the justifications for this policy decision and why this decision was not implemented in the metropolitan municipal area. This chapter concludes with a summary of the main findings and a brief discussion on the importance of this chapter in relation to Chapter 5.

#### **4.2 Integrating primary health care service delivery and management**

Health service provision has been plagued by the fragmentation of health service delivery and management. Both the PGWC and the municipalities in the Western Cape Province contribute to the costs of primary health care services and they also provide these services. The integration of primary health care service delivery and management was an initial aim for creating a DHS in the Western Cape Province. One of the main aspects of DHS implementation is that a single authority should manage and plan for the health services provided within a health district.

National health policy makers decided that functional integration was the solution to health system fragmentation. The Health MINMEC decided in July 2002 that “functional integration” should be implemented in all health districts (National Department of Health, 2003: 2).<sup>35</sup> Functional integration means, first, that provincial

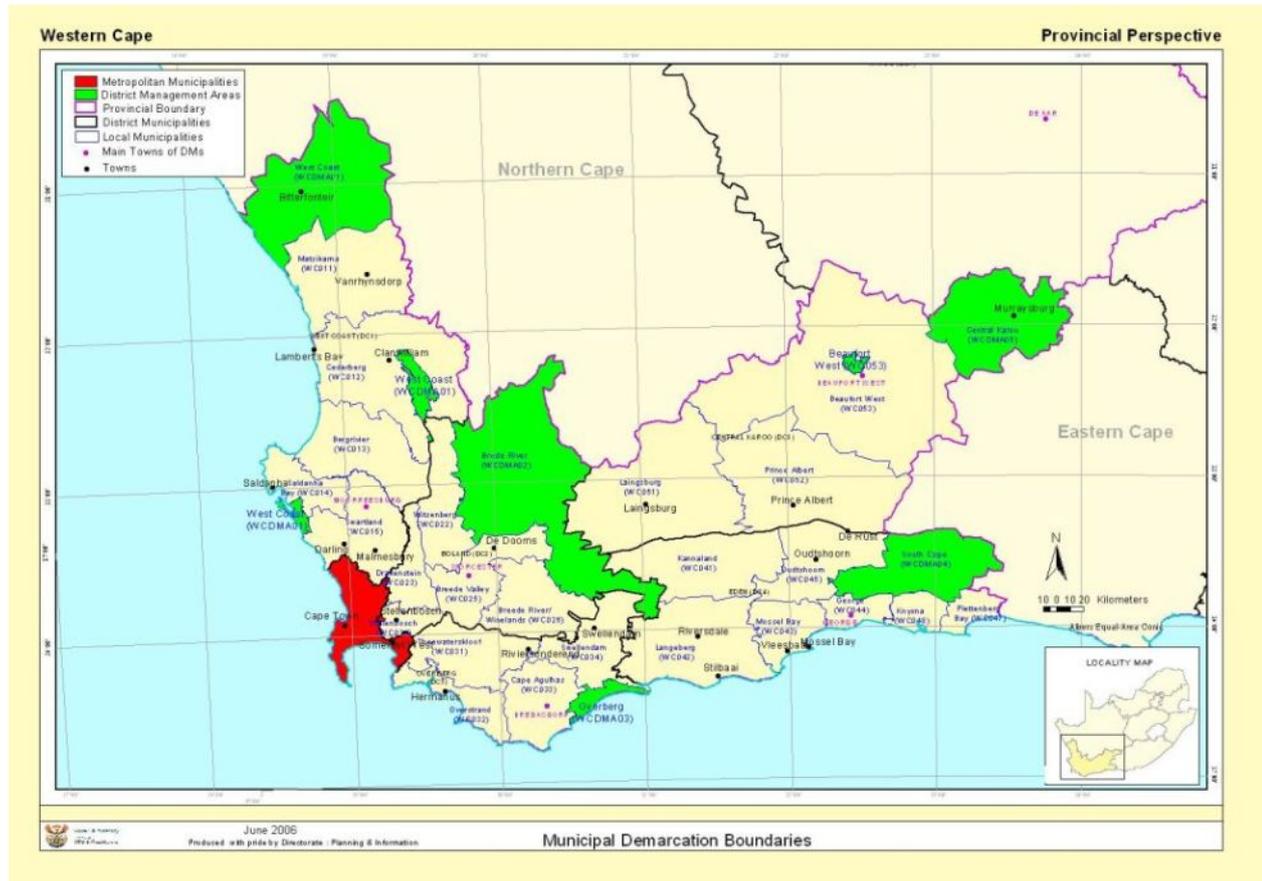
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<sup>35</sup> The Health MINMEC is a policy committee comprising the national Minister of Health and the nine provincial Members of Executive Councils (MECs). This body acts as a co-operative governance forum on health matters. When the National Health Act came into effect in 2005, the National Health Council replaced the MINMEC.

and local governments need to integrate their respective health services (Department of Health, 2003: 3), and second, that the “health-rendering authorities” need to create regularity in how they co-operate and collaborate, so that they can deliver on health policy goals, including “decreasing fragmentation and duplication, [and] enhancing integrated service provision” (Department of Health, 2003: 3).

There are three types of municipalities that constitute local government in South Africa: metropolitan, district and local municipalities. In the Western Cape Province there is one metropolitan municipality, five district municipalities and twenty-four local municipalities. The following map shows the boundaries of the provincial government of Western Cape Province as well as the boundaries of the various types of municipalities in the province.

## Map of the Western Cape Province showing the provincial and municipality boundaries



Source: Republic of South Africa, Department of Water Affairs and Forestry.

[http://www.dwaf.gov.za/dir\\_ws/WSNIS/maps/wc\\_dem\\_boundary\\_a3.jpg](http://www.dwaf.gov.za/dir_ws/WSNIS/maps/wc_dem_boundary_a3.jpg)

Implementing functional integration in this province means that the Department of Health (PGWC) and the health agencies in the twenty-nine municipalities must integrate their primary health care services and that the health management authorities need to work together to provide integrated services. As a step toward establishing a DHS, functional integration in the metropolitan area implied that City Health and the Metropole District Health Services (MDHS) should integrate their respective health

services and they should work together to facilitate the integration of health service delivery and management.

The discussion in this section firstly presents the state of health system fragmentation, particularly in primary health care service delivery and health management in the metropolitan municipal area. After each discussion I describe the decision and activities undertaken by the MDHS and City Health to implement functional integration in the metropolitan municipal area.

*The problem: fragmentation at the frontline of health service delivery*

The main characteristics of health service delivery fragmentation are, first, that the Department of Health (PGWC) and City Health (CoCT) each provide a part of the primary health care services package. The Department of Health's health personnel (PGWC) offer mainly curative health services. These health services include services such as child curative services, district and specialised hospital services such as 24-hour casualty and maternity units, rehabilitation services at specialised tuberculosis (TB) hospitals and terminal care services at sub-acute facilities (MDHS Annual Report 2004: 31-33). City Health's health personnel provide prevention and health promotion services such as TB screening, HIV testing and counselling services, child health services such as immunisation and developmental assessment and family planning services.<sup>36</sup>

Second, both health authorities provide their respective health services in different locations. For example, these services could be provided in a health facility or in the

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<sup>36</sup> City Health, City of Cape Town.  
<<http://www.capetown.gov.za/clusters/health.asp?IDPathString=1123-1375&clusid=245&catparent=1375>>

community. The PGWC Department of Health's facility-based health services are provided in 23 stand-alone community health centres, clinics, 6 maternity obstetric units (MOUs), 24-hour emergency units, 3 district hospitals and TB hospitals. The community-based services are home-based care, community-based IMCI, DOTS, group homes and services provided by non-health institutions such as schools, crèches, prisons and old-age homes and day-care centres (MDHS, 2004: 25).<sup>37</sup> City Health offers its set of primary health care services in 3 reproductive health clinics, 71 clinics, 18 satellite clinics, and 8 mobile clinics in the metropolitan municipal area of the Western Cape Province (MDHS, 2004: 25).

Each authority, the PGWC and the City of Cape Town provides its component of primary health care services in their own health facilities. For example, the Department of Health (PGWC) would offer curative health services in community health centres (MDHS, 2003: 31). Community health centres are larger buildings with more medical equipment because they service the curative needs of patients. Municipality nurses provide their prevention and health promotion services mainly in clinics. Clinics are usually smaller buildings, with a small staff component and with basic health care equipment for preventative health work such as immunisation. Mobile clinics refer to minibuses that have been converted to facilitate providing personal primary health care services to people who do not have access to a clinic in their area. In practice this means that a nurse drives to the designated areas where people have limited or no access to personal primary health care service facilities, where he/she will then provide these services.

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<sup>37</sup> The Directly Observed Treatment (DOTS) programme refers to a reminder system for patients to take their medication.

On a practical level, a fragmented primary health care service means that when a patient goes to a health facility he/she would find that the health personnel are from one authority and they provide therefore provide specific primary health care services. If the patient suffers from a condition that does not fall within the ambit of the services provided in that specific facility, he or she would then be referred to another facility, which would probably be run by another authority. It is also possible that the other facility is a distance away from the facility where the patient had initially sought assistance.

Furthermore, primary health care services fragmentation is problematic for the efficient operation of the health system because it produces duplication. Duplication may be understood in two ways; there is duplication of health service delivery in community centres and health clinics because the split of health service provision by the two authorities is not that clear in practice. For example, a PGWC nurse at Vanguard CHC described the duplication of health services in the following way:

We had duplication in services here. I mean we do family planning, day hospital family planning and paediatrics family planning, and so that caused a lot of problems, it actually causes confusion among the patients you know (about) which side to go....Also we needed to get the chronic services also onto the day hospital....It's not a preventative service, it's a chronic service so it belongs to the day hospital. We had a lot of disagreements and meetings, some of them went on from when this building opened, we've been meeting for almost three years.<sup>38</sup>

The quote describes the situation when the Department of Health (PGWC) and City Health jointly decided that they would integrate their respective primary health care services in some health facilities in the metropolitan municipal area. I will return to this

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<sup>38</sup> Interview with nurse at Vanguard Community Health Centre on 13 March 2006. (Nurse interview number 11)

decision and its implications later on. However, it is important to note that when the nurses from these authorities were integrated, meaning the nurses were to provide provincial and municipality primary health care services in one health facility, it was found that the nurses from both authorities had been providing family planning.

Duplication also refers to the use of double the resources for primary health care service delivery. A nurse at Kasselsvlei CHC described the implications of duplication: “But we now we have to do our own withdrawals of blood, injections and we have to put on our own nebs [nebulisers] and it’s duplication because we must have our own little box, but we are in one facility.”<sup>39</sup> This nurse’s comment highlights the fact that when the health service providers from the PGWC and the CoCT work separately, they have separate equipment and medical disposal facilities, and this suggests that double the resources are used as there is no integration. For example, money may be wasted on buying double the number of medical waste disposal boxes, because each authority provides its services separately.

National policy initiatives for developing a DHS based on a single primary health care approach were meant to resolve these kinds of fragmentation problems. The National Department of Health notes in its “Guidelines for functional integration” that it envisions a fully functional DHS as one where “all staff working at district level will be on the same conditions of service, with a single local government employer and a single management structure” (Pillay *et al.*, 2003: 3). Eliminating health service delivery fragmentation is an important challenge for DHS implementation, because it is a long-standing state of affairs and the changes required are quite substantial.

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<sup>39</sup> Interview with nurse at Kasselsvlei Community Health Centre on 10 March 2006. (Nurse interview number 8)

There are a number of issues which complicate the elimination of health service delivery fragmentation. Firstly, nurses from provincial government and municipalities receive different salaries (Bachmann and Makan, 1997). They also have different conditions of service and it is difficult to reconcile these. This is partly because municipalities are not part of the public service and they have their own salary scales and conditions of service. If there are attempts to integrate primary health care service delivery simply through staff integration, this means that health personnel may be working together in one facility but they could be earning different salaries for the same work. An IMATU trade union official (1) noted that such a situation arose with the provincialisation of Emergency Medical Services in the Western Cape Province, where ambulance personnel working side by side had different salaries and service conditions.<sup>40</sup> According to IMATU trade union official (1), the labour legislation provides for such a transfer:

The act, the Labour Relations Act, they made provision for that transfer as opposed to the common law, 'cause there's a section here called section 197, which basically says if a business or undertaking or a service is transferred as a going concern, the contract of employment transfers automatically to the new employer on the same terms and conditions as what they currently enjoy with the old employer.<sup>41</sup>

Even though it is possible to transfer health personnel from one authority to another under the current labour legislation, the differences between work expectations and salaries between health personnel could derail the operation of integration in practice. In other words, it is important that any solution to health service fragmentation take into account the possible implications of different salaries and service conditions for

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<sup>40</sup> Interview with an IMATU trade union official (1) at the IMATU office in Cape Town on 27 March 2006.

<sup>41</sup> Interview with an IMATU trade union official (1), 40.

health service delivery.

Another significant challenge to health service delivery fragmentation is that both authorities in the metropolitan municipal area contribute funds for primary health care service delivery. For example, MDHS spent R583 298 000 in the 2003 to 2004 financial year (MDHS, 2004: 69), which comes mainly from the Western Cape Department of Health, for health service provision in the metropolitan municipal area. This MDHS budget covers both the primary health care services and hospital services (CHSO, 2002: 1 of section Directorate). City Health, in contrast, provided R110 188 000 to primary health care service delivered in the metropolitan municipal area in the 2003/2004 financial year (MDHS, 2004: 73). In practice, if functional integration meant a transfer of primary health care services, then the authority that receives the personnel during the transfer must have sufficient funds to afford the costs of all transferring health personnel and the service delivery costs. These figures suggest that the PGWC would need to have more than doubled the amount of funding which it was putting into primary health care service delivery and management to afford the responsibility of primary health care service delivery in the metropolitan municipal area.

*Integrating primary health care services at the frontline of service delivery*

The Provincial Administration of the Western Cape (PAWC, predecessor of PGWC) together with the health department of the Unicity (predecessor of City of Cape Town municipality) started integrating health service provision in health facilities in the

metropolitan municipal area of the Western Cape Province from 1993 onward.<sup>42</sup> Primary health care service providers, who were respectively employed by the PAWC and the Unicity, were reorganised and placed in one health care facility.<sup>43</sup> This form of integration was applied in 22 of the 44 community health centres in the metropolitan municipal area (CHSO, 2003: 15; MDHS, 2004: 26). It is unclear why integration strategies were only applied in fifty percent of the health facilities. I will discuss below the state of affairs in two of the 22 community health centres where integrated primary health care service delivery was provided in the metropolitan municipal area during this time.

My research indicates that between 1994 and 2006 the City of Cape Town and PGWC health management officials adopted three different strategies to integrate primary health care service provision within health facilities in the metropolitan municipal area. I have identified these strategies from different data sources: the interviews with nurses at Kasselsvlei and Vanguard Community Health Centres, interviews with provincial and municipality health management officials, and the annual reports of the CHSO (2003: 38) and MDHS (2004). I have labelled these integration strategies as full integration, minimal integration and single-authority integration. These categorisations are based on the nature and extent of the integration within health facilities.

It is important to discuss these different health service integration strategies primarily because they are the first steps toward establishing a DHS within a health district in the

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<sup>42</sup> This date is taken from an interview with a PGWC nursing sister at Kasselsvlei Community Health Centre, conducted on 13 February 2006.

<sup>43</sup> There were seven Local Authorities in what is now the metropolitan municipal area in the Western Cape Province. The Local Authorities were amalgamated under the Unicity municipality in 2000 after the Local Government elections. Then in 2003 the Unicity became the City of Cape Town, a metropolitan municipality.

Western Cape Province. Metropolitan and district municipalities, which are two components of the local sphere of government in South Africa, were identified as health districts in the National Health Act (Republic of South Africa, 2004: 38). The National Health Act (Republic of South Africa, 2004) confirmed a 2001 MINMEC decision that “District and Metropolitan Council areas shall be the focal point for the organisation and co-ordination of health services” and this created an association between health districts and politico-administrative structures, namely local government structures in South Africa (Barron and Asia, 2001: 20). As there are 6 metropolitan municipalities and 47 district municipalities, South Africa has 53 health districts. The City of Cape Town is the metropolitan municipality in the Western Cape Province and its municipal boundaries constitute a health district. The discussions of the strategies provide an insight into how health management officials from City Health and MDHS have sought to deal with the challenges of primary health care service integration.

I refer to the first integration strategy for health service integration as full integration. This refers to a situation where health personnel, meaning nurses and specialists, from the PGWC and City Health provide primary health care services as a team and provide these services in one health facility. The health facility is usually a Community Health Centre. A MDHS manager referred me to Kasselsvlei Community Health Centre (formerly Bellville Community Health Clinic) as an example of a facility where full integration was implemented in the metropolitan municipal area.<sup>44</sup> Full integration complies with policy expectations that all staff should be able to provide most services irrespective of the authority for which they work (Pillay *et al.* 2003).

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<sup>44</sup> Interview with MDHS manager at MDHS offices in Woodstock on 25 January 2006

Most nurses from the Department of Health (PGWC) and City Health were positive about integration. The nurses at this facility with whom I conducted interviews made the following positive comments about integrated service delivery: there was no duplication, nurses provided health services that were not traditionally theirs, and they had access to training courses provided by the other authority.<sup>45</sup>

A key feature of integration in this facility was that nurses from the two authorities were sharing work, training and refreshments. The Department of Health (PGWC) staff mentioned that they were able to attend training courses offered by City Health, they had one facility meeting and all staff provided all health services.<sup>46</sup> The City of Cape Town staff mentioned that the Department of Health (PGWC) staff were learning what City Health's personnel knew because they went for training.<sup>47</sup> They shared the ordering of refreshments, they had one meeting for the facility, they learned through working together and there was no need to send patients from one authority to another. A PGWC nurse at Kasselsvlei CHC describes what integration meant in practice:

We, for example, when we saw a baby that needed to be nebulised, we would write up the treatment and send the child to the emergency room, irrespective of whether a PAWC (Provincial Administration of the Western Cape) or COCT (City of Cape Town) sister was there and they would nebulise the child and we would do the same for injections and drawing blood.<sup>48</sup>

A key point from this quote is that the employing authority did not matter when full integration was implemented in a health facility. The comments from the nurses at this

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<sup>45</sup> Interview with PGWC sister at Kasselsvlei Community Health Centre on 13 February 2006. Interview with PGWC sister at Kasselsvlei Community Health Centre on 10 March 2006.

<sup>46</sup> Interview with PGWC nurses at Kasselsvlei Community Health Centre on 13 February 2006 and 10 March 2006.

<sup>47</sup> Interview with CoCT nurses at Kasselsvlei Community Health Centre on 10 March 2006

<sup>48</sup> Interview with CoCT sister at Kasselsvlei Community Health Centre on 10 March 2006.

facility initially created the impression of a situation where the employing authority was less important, because nurses from both authorities were jointly providing primary health care services, instead of nurses from each authority only providing their own services. This would then be contrary to the earlier stated expectation, which was that there would be tension between nurses, because they had different salaries and service conditions as they worked for different governing authorities. However, it was not always easy, as a nurse from Kasselsvlei indicated that these were issues when they started out as an integrated health facility:

Work-wise it is OK, because we are there to help the patient and the patient can be seen, but in the beginning it wasn't so because we experienced problems with personnel - like attitudes and salary differences and the time differences that we start at seven o'clock, they start at eight o'clock. In the beginning there was a little bit, then things seemed to become better and we were getting on better.<sup>49</sup>

The tension was highlighted later on when nurses noted that they were not fully integrated after December 2005.<sup>50</sup> One of the nurses referred to their current service delivery situation as 'disintegration' of primary health care service delivery within that facility. She explained what she meant by 'disintegration' as follows:

...the 20<sup>th</sup> December we disintegrated last year. Since then we are working in one building but separate,... since December there was a small little problem, because PAWC said that we could go home the 23<sup>rd</sup> of December and the 31<sup>st</sup> December...eleven o'clock,... the COCT people said they can go home at one o'clock...<sup>51</sup>

This quote indicates that integration in the Kasselsvlei health facility ended because the two management authorities, MDHS and City Health, sent out different leave times for

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<sup>49</sup> Interview with PGWC sister at Kasselsvlei Community Health Centre on 13 February 2006.

<sup>50</sup> Interview with PGWC sister at Kasselsvlei Community Health Centre on 13 February 2006.

<sup>51</sup> Interview with PGWC sister at Kasselsvlei Community Health Centre on 13 February 2006.

their respective staff for the Christmas holiday. This means that the differences between health staff in this facility had remained an important issue, albeit an underlying one. Furthermore, the interviewee indicated that the health staff in Kasselsvlei Community Health Centre chose to revert to a situation where each provided their respective primary health care services without the knowledge and blessing of the health management from either authority. This is important because it demonstrates that health service integration is affected by the relationship between the health personnel at the front line of health service delivery. This is a recurrent theme in the discussions of a minimally integrated health facility in the metropolitan municipal area.

The second form of integration, minimal integration, refers to a situation where health service providers from the PGWC and City of Cape Town offered their respective components of PHC services separately, while they were housed in one health facility. This form of integration was implemented in 21 health facilities. An MDHS manager recommended Vanguard CHC as an example of a health facility where this kind of integration had been implemented since 2000.<sup>52</sup> When I asked how health services were provided in this facility, a PGWC nurse indicated that a key feature of the integration in this facility was separation:

So now there are those things that this is our building, this is not your building, I'm talking about the staff members now, this is not your building, this is our room with our equipment, this is ours, even the tea room, if you go to the tearoom we are separated. This side is PAWC and this side is Unicity. But when we came over the building was built in such a way that we share the same tearoom.<sup>53</sup>

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<sup>52</sup> Interview with MDHS manager at MDHS offices in Woodstock on 25 January 2006.

<sup>53</sup> Interview with PGWC nurse at Vanguard Community Health Centre on 10 February 2006.

The City of Cape Town nurses mentioned that nurses from both authorities provided their own functions, that there was a duplication of some services, initially no provision for a well-baby clinic, separate meetings and differences between the staff from the two authorities in terms of salaries and refreshments, race issues between staff and favouritism.<sup>54</sup> The PGWC staff mentioned features such as the fact that health staff from the two authorities provided their health services separately, differences in conditions between the health staff from the two authorities in that PGWC nurses worked on weekends and City of Cape Town nurses did not, duplication of services like pap smears, separate cleaners, two facility managers, separate tearoom, differences in the quality of refreshments and extent of consultation of staff (PGWC staff consulted City of Cape Town staff more).<sup>55</sup> There was also racial tension between the staff from the two authorities. It is unclear whether this situation existed in other health facilities where minimal integration was attempted. It is important to note, though, that this health service delivery integration strategy was applied in nearly half of the community health centres in the metropolitan municipal area. This means that minimal integration has been applied in almost half of the provincial government-owned health facilities. If the same difficulties are experienced in all the facilities, a substantial proportion of these facilities could be hampered in delivering services.

The third form of integration, single-authority integration, was to be implemented from April 2006 in 8 health facilities. In 2005 the health district management, meaning

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<sup>54</sup> Vanguard Community Health Centre serves two population groups from two distinct areas. The one population is black and from Langa, a former township. The other is the predominantly coloured population from Bonteheuwel. Vanguard CHC is located on the periphery of the previously coloured residential area and the black clients travel to Vanguard CHC from Langa. The staff in Vanguard CHC to a certain extent reflect the racial mix of patients, because the staff who moved into this facility had previously worked in these respective areas.

<sup>55</sup> Interviews with PGWC nurses conducted at the Vanguard Community Health Centre on 10 February 2006.

MDHS and City Health senior management, decided that 8 of the 21 minimally integrated health facilities should be changed to single-authority facilities where comprehensive PHC services would be provided. This type of reintegration meant that either health staff from the PGWC or the City of Cape Town would move out of a minimally integrated health facility and the remaining staff would be trained to provide comprehensive PHC services. In a Department of Health document entitled “A Comprehensive Primary Health Care Service Package for South Africa” (Peterson, 2001: 11) comprehensive primary health care services refer to all primary health care services provided in health facilities at the district level but excludes level-one hospitals. This means that, once implemented, the nurses in the 8 community health centres with single-authority integration would be able to provide all the prevention, health promotion and curative health services.

Single-authority integration would facilitate the development of the National Department of Health’s notion of full integration. However, this form of integration was only planned for 8 health facilities in the metropolitan municipal area. Senior City Health official (1) explained that they decided to create single-authority health facilities in these health facilities because of tensions between health staff: “We can where there’s been major tensions, where they spend more time fighting than they do spend focusing on patients, client care.”<sup>56</sup> The relationship between health personnel from two authorities is again raised as a problem for integrating primary health care facilities by integrating the health personnel. The latest solution from the health management is based on retraining staff from a single authority to provide comprehensive primary health care services in one health facility.

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<sup>56</sup> Interview with Senior City Health official (1) at City Health offices in Cape Town on 31 October 2005.

The decision to create 8 single-authority integrated health facilities would create a situation where the PGWC health service providers would provide comprehensive PHC services in five community health centres, while the City of Cape Town health service providers would do the same in three community health centres.<sup>57</sup> This type of integration is significant, because it would realise the Department of Health's plan for having comprehensive PHC services provided in one health facility. Furthermore, it eliminates the problem of tensions between health personnel who work for two different authorities, with different salaries and service conditions, but who work in one health facility and yet do not integrate their respective health services.

In summary, the predecessors of MDHS and City Health began joint planning for health service integration in the metropolitan municipal area even before the first democratic elections in South Africa in 1994. By 2006, rather than adopting a single strategy for health service integration, three implementation strategies had been selected. Two of these strategies, full integration and minimal integration, were implemented in half of the provincial government health facilities. The decision to create single-authority integrated health facilities was a response to internal tensions between health personnel from the two authorities in some minimally integrated health facilities. This shows that the PGWC and the municipality health management in the metropolitan municipal area had the scope to adopt various strategies for implementing national health policy goals related to removing fragmentation and duplication in health service delivery.

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<sup>57</sup> Interview with senior City Health official (1), 56.

Attempting to integrate primary health care services in health facilities is problematic when the health personnel who are meant to be integrated in fact work for two different governing authorities. There may be two reasons for this. First they are placed on different salary scales and have different conditions of service, as described above, and second, the health personnel split themselves along organisational lines in that they think about themselves as part of different and competing organisations. This was evident in the language that nurses used when I asked them about health service integration in the health facility. In particular they identified themselves and referred to the other health personnel in collective terms and on the basis of the organisation they work for. CoCT nurses would refer to PGWC nurses as PAWC nurses and PGWC nurses would refer to the other nurses as City or Unicity nurses.<sup>58</sup>

Furthermore, the City Health nurses were providing the preventative and health promotion services on one side of the building, while PGWC nurses offered curative and other services in another section of the building. The CHC had different waiting rooms, the main waiting room in the centre and an additional waiting area where the City Health nurses consulted with patients. The geographical separation could be interpreted as functional because, as one nurse at Vanguard CHC indicated, they could not have ill persons and healthy babies in one waiting area.<sup>59</sup> However, based on the interview comments on how integration works within the health facility, this may be interpreted as a physical separation of the space between the nurses from the two health authorities. Another example of the separation of physical space was that the cleaners cleaned only the area of the health facility they associated with their organisation.

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<sup>58</sup> Provincial Administration of the Western Cape (PAWC) was the old name for the government in the Western Cape Province.

<sup>59</sup> Interview with City Health nursing sister at Vanguard CHC on 13 March 2006.

*Fragmented health services management in the metropolitan municipal area*

Fragmentation is a key feature of the management of primary health care services because the Department of Health (PGWC) and the City of Cape Town municipality have two separate management structures. MDHS is the provincial health management agency and City Health is the municipal health management agency. In this section I describe how primary health care services are managed in the metropolitan municipal area.

It is important to understand health service management fragmentation for two reasons. First, there are implications for realising other health system reform goals. The key problem with having two authorities who manage primary health care services through two agencies is duplication. Duplication highlights the inefficiency in the way that the health system operates, because the double management means increased costs of primary health care services. As one of the key goals of health system transformation is to extend people's access to public health services, duplicated management costs redirect funds away from realising such goals. Second, unpacking health system management allows one to see whether the health system management is moving toward a DHS.

Metropole District Health Services (MDHS), the provincial health management agency, is a regional health management organisation within the provincial Department of Health (PGWC). The MDHS is a directorate of the Department of Health (PGWC) and is accountable to the Chief Director for District Health Services. The Department of Health (PGWC) is located in the Central Business District of the City of Cape Town.

The MDHS offices are located in Woodstock, a suburb just outside the central business district of the City of Cape Town. In 2004 MDHS had a total staff complement of 347, of which 285 positions were filled and 62 positions were vacant (MDHS, 2005: 32).

MDHS was established in 2003. There are three important aspects about the Department of Health's establishment of the MDHS: the structures that were incorporated to create the new agency, the extension of the responsibilities of this agency, and its location within the Department of Health's organisational structure.

Before 2001 the Community Health Services Organisation (CHSO), an agency within the Department of Health (PGWC), managed a large part of the National Primary Health Care package (CHSO, 2003: 6) in the metropolitan municipal area. The National Primary Health Care package was comprised of health services provided in clinics, mobile clinics and community health centres and health services provided in the community (Petersen, 2001: 11). The CHSO was responsible for 49 community health centres, of which 9 were 24-hour facilities, 5 Midwife Obstetric Units and 7 Reproductive Health Centres (CHSO, 2003: 6). Dr Kane-Berman, a Department of Health (PGWC) official, conducted a departmental investigation into the CHSO and recommended that it become a directorate to address structural and administrative matters (CHSO, 2002: 1 of section Directorate). The nature of the structural administrative matters that creating MDHS would resolve was not clarified in the CHSO Annual report for 2002.

In February 2001 the CHSO was incorporated, with other Department of Health (PGWC) provincial management structures, into the Metropole District Health Services

(MDHS), a new provincial health management organisation.<sup>60</sup> MDHS was formed out of the CHSO, Metro Health Programmes Division, three District Hospitals, the Brooklyn Chest TB Hospital and step-down facilities (MDHS, 2004: 22) MDHS was tasked to “plan, manage and evaluate a comprehensive Primary Health Care Service in the Metropole Region – Department of Health ... liaise and coordinate with tertiary- and secondary-level tertiary health care services, other regions, academic institutions, non-governmental organisations, private health care providers, and financial transfer and monitoring of Local Government” (CHSO, 2002: 1 of section Directorate). Its management scope included specialised TB hospitals, trauma and emergency services, rehabilitation services, and planning and managing Primary Health Care in the metropolitan region (MDHS, 2004: 2).

The creation of MDHS extended the management scope for this regional directorate beyond managing primary health care services. The National Primary Health Care package notes that primary health care services comprise those health services provided in clinics, mobile clinics and community health centres as well as health services provided in the community (Petersen, 2001: 11). The MDHS was responsible for primary health care services and some hospitals.

The creation of MDHS finalised the regional health management structure of the Department of Health (PGWC). The Department of Health (PGWC) has a Chief Directorate: District Health Services, which falls under the Division: Secondary,

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<sup>60</sup> The CHSO continued to produce annual reports until 2003, when MDHS released its first annual report.

Tertiary and Emergency Services.<sup>61</sup> This Chief Directorate initially had the following regional health management offices for non-metropolitan areas of the Western Cape Province: Boland/Overberg, Southern Cape/Karoo and West Coast/Winelands. These regional health management agencies are all directorates within the Chief Directorate: District Health Services. MDHS also became a directorate under the Chief Directorate: District Health Services the Department of Health (PGWC).

MDHS manages the health district from a central location, their offices in Woodstock. The metropolitan municipal area was legally designated as a health district in the National Health Act (Republic of South Africa, 2004). According to the MDHS Strategic Plan (MDHS Strategic Plan, 2003: 14), the projected population in the area from the 2001 census was 2 920 418 people and the metropolitan area was divided into health subdistricts. The population in the metropolitan municipal area of the Western Cape Province is thus more than five times the recommended size for a health district. Up until 2003 there were 11 health sub-districts in the metropolitan municipal area (MDHS, 2004: 8). The number of health sub-districts in the metropolitan municipal area was later changed to 8 (MDHS, 2004: 8).

City Health is the City of Cape Town municipality's health department. The City Health offices are located in the Civic Centre in the central business district of Cape Town. City Health manages the health district through 8 health sub-district management offices. The sub-districts' management offices are located in the communities they serve. There are offices in the following health sub-district areas: Central, Eastern, Tygerberg, Northern Panorama, Southern, Mitchell's Plain,

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<sup>61</sup> The authority above the Chief Directorate is the Head of Department and the authority above this is the Member of the Executive Committee (MEC) for Health, the political head of the provincial health department.

Khayelitsha and Klipfontein. Each sub-district office has a manager and staff. The managers are collectively responsible for 3 reproductive health clinics, 71 clinics, 18 satellite clinics and 8 mobile clinics. Furthermore, they are responsible for their staff in the 22 community health centres, where the provincial and local government nurses offer health services in the same building (MDHS, 2004: 26). These City Health sub-district managers are accountable to the executive director of City Health.

In the next section I describe what the primary health care services management agencies in the metropolitan municipal area have done to integrate health management in the metropolitan municipal area.

#### *Integrating health services management*

The definition of functional integration indicates that the expectation is that provincial and municipal health care management agencies from the PGWC and the CoCT municipality should develop ways to work together. Cooperation between the authorities should be based on securing national policy priorities such as “decreasing fragmentation and duplication [and] enhancing integrated service provision” (Pillay *et al.*, 2003: 3). How was cooperation realised in the metropolitan municipal area? The City of Cape Town and the PGWC health management have cooperated over time through joint decisions and actions to facilitate health service integration. These joint decisions were made in joint management meetings in the metropolitan municipal area.

The provincial and municipal health management agencies began cooperating quite early. For example, a nurse noted that Kasselsvlei health facility was turned into a fully

integrated primary health care facility some time in 1994.<sup>62</sup> At that time the metropolitan municipal area comprised seven separate municipalities. The City of Cape Town metropolitan municipality only came into being in 2000. Therefore in 1993 the cooperative decision would have been between the PAWC health department and the municipality health department under whose jurisdiction Bellville South lay. The joint decision in 1993 indicates that a cooperative relationship between provincial government and municipality health managers had been sustained over some time and culminated in MDHS and City Health deciding jointly in 2005 to create single-authority facilities.

The health management teams from the PGWC and the City of Cape Town met regularly. These interactions between the two authorities in the metropolitan municipal area occurred through three levels of joint management structures. One of these structures was a Provincial Steering Committee, which was comprised of the Department of Health (PGWC) and the Unicity.<sup>63</sup> A second structure was Metro District Executive Committee (MDEC), where the CHSO and the Unicity met. Then there was the Integrated District Management Team (IDMT), which included the health district and sub-district managers from both authorities. As this chapter focuses on the metropolitan municipal area I will only discuss the joint health management structures at that level, which are the MDEC and the IDMT.

Initially, the MDEC and the IDMT met every two weeks and every six weeks respectively (CHSO, 2002: 3 of section Directorate). The MDEMC was the joint health management structure for City Health and Metropole District Health Services (MDHS)

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<sup>62</sup> Interview with a PGWC nurse at Kasselsvlei Community Health Centre on 13 February 2006.

<sup>63</sup> This was the name of the unified municipalities in what is now the metropolitan municipal area in the Western Cape Province. The Unicity was the precursor to the City of Cape Town.

in the metropolitan municipal area. The management team consisted of six people, the MDHS director, Dr Bitalo, and the executive director of City Health, Dr Toms, and two managers each from City Health and Metropole District Health Services respectively.<sup>64</sup>

Since 2001 the number of joint management meetings decreased from every two weeks to one meeting every month. These meetings were held alternately at City Health offices in Cape Town and the MDHS offices in Woodstock. I attended two of these meetings, once in 2005 at the MDHS offices when the joint management structure was still called MDEMC. I attended a second meeting in 2006, when MDEMC was renamed District Executive (DEX).

The key agenda issues at DEX meetings were operational issues related to health service delivery within the health facilities. One of the agenda items was waiting time surveys, which an outside agency was conducting. The surveys were important initiatives, because they could offer an insight into where faster service delivery is needed and what factors increased waiting times in health facilities in the metropolitan area. The discussion in the meeting was about progress with the waiting time surveys. Another important aspect of these meetings was deciding how to address the issues on the agenda. I observed that decisions were taken more by consensus between the two directors rather than by consensus within the group. When one director proposed a decision, he looked to the other director to confirm that there is agreement on the way forward. Based on these observations one could perhaps suggest that the cooperative

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<sup>64</sup> The managers present at the meetings were Dr Bhanu Daya (stood in for Dr Martell at first meeting) and at the second meeting Dr Rob Martell, managers from Metropole District Health Services. Dr Ivan Bromfield, the manager of special health services department in City Health and Mr Andile Zimba, a sub-district manager from City Health were at both meetings.

engagement was a product of the interpersonal relationship between the two senior managers of MDHS and City Health.

The Integrated Management District Team (IMDT) is another important cooperative forum. It is comprised of the district and sub-district managers from the PGWC and the City of Cape Town (MDHS/City of Cape Town, 2004: 3). The IMDT met initially on 16 April 2003 and this is where the district planning processes began (MDHS/City of Cape Town, 2004). A final draft of the metropolitan district health plan was prepared on 7 April 2004. The IDMT developed the District Health Plan for PHC service delivery in the metropolitan municipal area from 2004 to 2006 (MDHS/City of Cape Town, 2004: 3). The district health plan outlined what joint planning could mean for improved service delivery infrastructure. The two authorities agreed on the kinds of capital works needed to expand and upgrade the health facilities, and both the PGWC and City of Cape Town would therefore know which capital works projects they should plan for (MDHS/City of Cape Town, 2004). The IMDT was responsible for implementing and monitoring the District Health Plan (MDHS/City of Cape Town, 2004: x).

The health management agencies from these two authorities also cooperated to jointly plan for implementing HealthCare 2010, the PGWC Department of Health's new plan for its health service delivery in the Western Cape Province. The strategic planning document, which the two metro authorities developed jointly, is dated September 2003. The cooperative planning committees included health managers and other officials from City Health, City of Cape Town officials, MDHS and the Department of Health

(PGWC) management. The strategic planning document outlines how HealthCare 2010 would be implemented in the metropolitan municipal area.

These activities suggest that there was a good cooperative relationship between MDHS and City Health. The objective of integration, however, was to move toward a unified DHS, with one authority responsible for primary health care services within a health district. This kind of health management integration in the metropolitan area is complex, because the expected and the practical relationships between these health authorities are conflicting.

The expected relationship between the two authorities is affected by their relationship as two spheres of government – the provincial sphere and the local sphere of government. Chapter 3 of the South African Constitution (Republic of South Africa, 1996) describes co-operative governance as the framework for intergovernmental relations in South Africa. South Africa has three spheres of government: national, provincial and local government; their relationship according to the Constitution is that these spheres are “distinctive, interdependent and interrelated” (Republic of South Africa, 1996: 25). The spheres of government are required to “co-operate with one another in mutual trust and good faith” by, amongst other principles, “informing one another of, and consulting one another on, matters of common interest” (Republic of South Africa, 1996: 25-26). It is expected that the spheres of government should “exercise their powers and perform their functions in a manner that does not encroach on the geographical, functional or institutional integrity of government in another sphere” (Republic of South Africa, 1996: 25). The provisions in the Constitution thus

indicate that City Health and MDHS are under an obligation to speak to each about health service delivery because they should act cooperatively.

The second relationship is the actual service delivery relationship between City Health and MDHS. The Department of Health (PGWC) views the provision of primary health care services as its function based on the National Health Act of 1977 (Western Cape Department of Health, 2004: 13). The understanding of their relationship, based on the Act, was that the municipalities were providing health services on behalf of the Department of Health (PGWC). This meant that municipalities, as health service delivery agencies, were meant to be accountable to provincial government.

But if the municipalities were merely contractual agents, one would have expected that the PGWC would pay the full cost of service delivery to the City of Cape Town municipality. However, both authorities contribute funds to primary health services delivery in the metropolitan municipal area. The PGWC in the 2002 to 2003 financial year contributed 83 percent and the City of Cape Town contributed 17 percent of R586 million, which was the total cost for Personal Primary Health Care (PPHC) services in the metropolitan municipal area (MDHS/City of Cape Town, 2004: 22).<sup>65</sup> The PGWC allocates funding to the municipalities which provide primary health care services in the Western Cape Province. City Health is therefore accountable to the Department of Health (PGWC). MDHS is responsible for transferring the funds and monitoring how City Health uses these funds. This means that there is a contracting relationship between MDHS and City Health. The nature of the actual relationship between these authorities as it relates to funding does not facilitate cooperation.

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<sup>65</sup> Personal primary health care services are primary health care services excluding environmental health services.

There is evidence that the cooperative relationship sometimes falters. For example, the MDHS and City Health managers must have been aware of the tensions between the health personnel within integrated community health centres, which I discussed earlier under the theme of primary health care services integration. One would therefore have assumed that they would have agreed on Christmas vacation leave times for both authorities to avoid tensions. The lack of such basic consultation was part of the reason why ‘disintegration’ happened in Kasselsvlei Community Health Centre, which was the only fully integrated health facility in the metropolitan municipal area.

The other side to the cooperative relationship also began to show with the matter of the Service-Level Agreement (SLA), a contract between the authorities, which outlines the responsibilities of each of the contracting parties. Up until the end of April 2006, when my fieldwork ended, the SLA between the PGWC and the City of Cape Town had not yet been signed.<sup>66</sup> This means that in practice there was no legal clarity on the mutual obligations of the Department of Health (PGWC) and City Health. A MDHS manager described the situation regarding the SLA as follows:

So the service-level agreement is about funds but with specific outcomes and then the monitoring and evaluation of that and there’s agreement now and consensus on how that gets done. *So did the municipality sign?* They have not yet signed the service-level agreement with province. I know there was an accelerated meeting and one of the issues that they said they want to conclude is you know the financial stuff... I don’t know what... input has been in that regard. Why it’s not been done... he has always said who do I send it through, because you know it doesn’t go through to Mayco or to their channels of communication or who is their responsible person to endorse it.<sup>67</sup>

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<sup>66</sup> Interview with MDHS manager at MDHS offices in Woodstock on 19 January 2006.

<sup>67</sup> Interview with MDHS manager at MDHS offices in Woodstock on 19 January 2006.

The first important point was that the SLA was a financial regulation requirement based on national legislation, in particular the Public Finance Management Act (1999). Therefore the MDHS was legally obligated to hold the municipalities accountable for the money that they received from the Department of Health (PGWC). The second important point is that the progress with the SLA seemed to have been delayed on the side of the City of Cape Town municipality. The trouble with finalising the SLA was not unexpected, as these are two separate governing authorities who also compete for power. I return to this theme on competition for power when I discuss the analysis of the data.

While the SLA remained unsigned, MDHS and City Health directors continued to cooperate through the joint management structures referred to earlier. Irrespective of these issues, Senior MDHS official (1) noted that he and the City Health manager tried to present a united front and have developed ways of checking with each other in order to prevent tensions from developing.<sup>68</sup> Furthermore, the integrated service delivery initiatives in community health centres also continued even though there was no SLA.

In summary, MDHS and City Health have collaborated at different levels to facilitate integrated primary health care service delivery in the metropolitan municipal area of the Western Cape Province. These interactive forums were created prior to the guidelines for functional integration. The two authorities providing primary health care services in the metropolitan municipal area were thus complying with the policy expectations relating to health management integration. There are two types of relationships between City Health and MDHS. The formal relationship is based on the expectation that they

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<sup>68</sup> Interview with senior MDHS official 1 at MDHS offices in Woodstock on 3 November 2005.

would cooperate, and then there is the service delivery relationship, which is one where the City Health director is accountable to the MDHS director. The tensions that I have outlined provide some insight into why functional integration in terms of health management integration is so complex.

Functional integration is but one aspect of transforming the health system, but there were other decisions that contributed to changing the health system in South Africa. In the next sections I discuss two significant policy decisions related to health system reform in the Western Cape Province.

#### **4.3 Policy decision 1: decentralising primary health care services is initiated**

When the South African national government adopted a district health system, they selected a decentralised model for health system reform. Decentralisation was a trend in health system reform (Litvak *et al.*, 2000: 1; Atkinson, 2002: 113) and in development circles (Galvin and Habib, 2003: 865; SLSA Team 2003). According to SLSA Team (2003: 85), reasons for decentralisation in South Africa included “the belief that many functions can be undertaken more effectively at local levels of government”, and “that national government wants to relieve itself of existing, or potential, fiscal pressure and administrative responsibilities.” The South African national government expected municipalities, as the lowest level of government, to eventually manage and run health districts (Pillay *et al.*, 2003: 3). Has there been any progress in creating a decentralised health system where municipalities run health districts?

This section describes the first initiative on the road to establishing a decentralised health system in the Western Cape Province. The first initiative was the PGWC

Cabinet's policy decision in principle that primary health care services in the metropolitan area may be transferred to the City of Cape Town. I discuss the decisions and activities that followed from this policy decision.

*Decentralising primary health care services is the preferred option*

On 6 August 1997 the provincial Members of the Executive Council (MEC) for Local Government, Mr Pieter Marais and the MEC for Health, Mr Ebrahim Rasool, created the Bi-Ministerial Task Team (BMTT) to investigate "the future governance of all primary health care (PHC) services in the Western Cape" (Department of Health and Social Services, 2000: 1). The task team was in fact exploring which authority should be responsible for the DHS in the Western Cape Province. The national health policy at the time, the White Paper on the Transformation of the Health System (1997) referred to three governing options that provincial governments could explore. Option one was that the provincial government becomes the authority over the DHS, option two was that the provincial government establish an independent health authority, and finally that a municipality could be made responsible for the DHS. The Bi-Ministerial Task Team recommended in their final report in April 2000 that the local government option, or the municipality-run DHS, be adopted for PHC services in the Western Cape Province (Department of Health and Social Services, 2000: 23). This recommendation was not limited to the metropolitan area. The BMTT recommended that the PGWC transfer primary health care services to the metropolitan, local and district municipalities in the province.

*The policy decision that set the Western Cape on the road to a decentralised health system*

In Annexure 1 the Health Services Task Team (2002: 1) noted that the “The provincial Cabinet of the Western Cape decided in October 2001 to transfer certain health services and functions to the City of Cape Town.” This was an important decision, because the PGWC was signalling that it supported the idea of a municipality taking responsibility for the DHS. The PGWC provincial cabinet was a coalition government at the time run by the New National Party (NNP) and the Democratic Party (DP).

The National Party had initiated the policy of separate development and had governed apartheid South Africa since 1948. The interesting point about this decision was that the African National Congress’s biggest rival at the time had taken a policy decision that was in line with the ANC-led national government’s health policy expectations. The importance of this point lies in the fact that there had been long-running tensions in the Western Cape between the NNP and the ANC, who were competing and continue to compete furiously for control of the province (Nizjink and Jacobs, 2000). The Western Cape Province was always one of the provinces that the ANC could not win on its own.

Furthermore, the National Party won the Western Cape Province in the first democratic elections in 1994 and as a provincial government it contested some of the national government’s actions. For example, it developed its own provincial constitution and it initiated a constitutional dispute over municipal boundaries related to gaining political ground (Cameron, 1996). In this context, however, an NNP Cabinet took a policy decision that would begin implementing the ANC-run national policy expectations for

health system reform in the Western Cape.

The PGWC mandated a Health Services Task Team in 2001 to plan the transfer of the CHSO to the City of Cape Town.<sup>69</sup> They were tasked to “drive the process of designing the new integrated PHC service within the City” (Health Services Task Team, 2002: Annex 1: 1). The framework within which they had to design these services was the National Health Bill with its definition of health services for local authorities, the implementation policies and guidelines from different spheres of government, and the internal restructuring process of the City of Cape Town (Health Services Task Team, 2002: Annex 1: 1).<sup>70</sup> The Health Services Task Team in their Final Report in March 2002 recommended a phased approach for transferring PHC services from the PGWC to the City of Cape Town. The transfer would begin in July 2002 and the last phase of the transfer would begin in July 2004 (Health Services Task Team, 2002: 6).

The key actors in the transfer negotiations were an outside agency contracted to facilitate the process, namely the Organisation for Africa Development (ODA), the provincial Department of Health and the Treasury, and the Cape Town Municipal Health Department. The implementation of the policy decision stopped at the planning phase for the transfer. As was previously mentioned, the CHSO noted in an annual report that the implementation process stalled as a result of a political-level problem involving three departments. In particular, the CHSO attributed the stalled implementation process to interdepartmental conflict and intergovernmental issues. The

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<sup>69</sup> The Health Services Task Team comprised representatives from the City of Cape Town Department of Health (City Health), the Provincial Department of Health, a consultant from the Health Systems Trust and a consultant from the Organisation Development Africa.

<sup>70</sup> The municipal elections took place in 2000 and the metropole area in the Western Cape Province was designated as one of six metropolitan municipalities in South Africa. This meant that the initial seven municipalities, which were operating in this area had to amalgamate. Initially the amalgamated municipality was called the Unicity, but was later renamed the City of Cape Town.

interdepartmental conflict was reported as being between the Department of Health and the Provincial Treasury. Senior provincial health official (1)<sup>71</sup> described the problem as:

The first and foremost thing is the Provincial Treasury said ... they will not, they have to sign the root form. They will not sign the delegation to local government. They will only sign what they call an assignment, which [was] what Constitution prescribes. They will support assignment from a financial risk point of view. Delegation to them amounts to an agency function, a service-level agreement,... the risks are too big in terms of quality assurance and monitoring and evaluation.<sup>72</sup>

Those inside the provincial health policy system thus suggest that various technical and inter-agency and intergovernmental complications led to the stalled implementation. However, the conflict seemed to centre on what type of decentralisation would be acceptable to the various parties. The above extract suggests that the Department of Health (PGWC) preferred that their primary health care services be delegated to the City of Cape Town. This type of decentralisation would create a situation where the provincial government was still responsible for primary health care services, but would contract the municipality to provide the services on its behalf. Delegation would change the operation of the health system in the sense that the provincial government would transfer its health management and health personnel to City Health. If implemented, the health management and the health personnel who were responsible for primary health care services in the metropolitan area would all be working under one authority, a municipal government, but the primary health care function would fall to the PGWC.

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<sup>71</sup> When I conducted interviews with more than one person in the organisation or department I have used numbers to distinguish between the officials.

<sup>72</sup> Interview with senior provincial health official (1) at Department of Health offices in Cape Town on 5 October 2005.

Senior provincial health official (1) indicates that the Provincial Treasury favoured assignment rather than delegation.<sup>73</sup> Assigning primary health care services to the City of Cape Town would have meant that the PGWC transfers the responsibility to the municipality. The PGWC would therefore no longer be financially responsible or accountable for primary health service delivery and management.<sup>74</sup>

Senior City Health manager (1) also argued in favour of the municipality taking over primary health care services. The main reason the senior City Health manager (1), offered in support of a transfer to the municipality was that decentralising to a municipality would be in compliance with expectations for establishing a district health system. This senior City Health manager argued the case as follows:

...that process goes against the principles of the district health system which we've got three spheres of government, so it should be at the lowest sphere, because you want a lot of community participation and interaction and you also want to approach it in a multi-sectoral approach, so you want it also linked to people putting in water, sanitation, housing, roads and that's all local government. So the obvious decision would be local government. They ignored all the principles when they developed the new act.<sup>75</sup>

The key argument here is that a district health system emphasises other health-related services such as environmental health services, and that the service providers should be

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<sup>73</sup> The Public Finance Management Act (Republic of South Africa, 1999: 27) stipulates that accounting officers are allowed to delegate powers and duties delegated to them subject to limitations imposed by the Treasury or the Act; another of provisions is that it does not "divest the accounting officer of the responsibility concerning the exercise of the delegated power or the performance of the assigned duty." Therefore if the function was transferred, the ultimate responsibility remained with the accounting officer.

<sup>74</sup> Van Zyl (2003) offers a way to understand the power of Provincial Treasuries. He argues that provincial governments are not acting within their powers, because the national government is constraining provinces through financial regulations and by not enacting legislation that would facilitate exercising their powers as envisioned in the South African Constitution. Moreover, he notes that the organisational culture of provincial treasuries is linked to a tradition of centralism and the close relationship between national and provincial treasuries means that the national government can control provinces through the National Treasury (Van Zyl, 2003: 32).

<sup>75</sup> Interview with Senior City Health official (1), 56.

involved in health district planning. He thus argued that the logical direction of a transfer should be from the provincial government to the municipality, as the municipality provides environmental health services and is closest to the people. In the metropolitan municipal area a long-standing Community Health Forum member (1) referred to the relationship between the forum and the municipality as being better than between the forum and the provincial government. He noted that “we the community have a very healthy relationship with the municipality, but we have a very poor relationship with the province because of the lack of commitment, because of their lack of understanding and because of their lack of co-operation.”<sup>76</sup> These kinds of comments about the relationship between the respective health authorities and the community representatives highlight central issues in the debates about governance of the DHS. In particular, they raise an important question about which sub-national level of government would best be able to deliver and manage comprehensive primary health care services?

Those who were involved in the Health Services Task Team process highlighted a number of factors that affected implementation. The main category of factors was technical aspects such as the costs of the transfer. Senior provincial health official (2) explained:

...we went through a procedure of preparing for it, making recommendations, even though those were never implemented, because there was no legislative framework and the financial implications just was too high. So there was never a political decision to implement, because you would require a political decision to be made which signed there for implementation, which would have been the

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<sup>76</sup> Interview with Community Health Forum member (1) at the University of the Western Cape in Bellville on 31 March 2006.

MEC for Local Government, the MEC for Health. And they never signed the recommendations... therefore the political decision was never made.<sup>77</sup>

An important point to note is that the respective MECs' for Health and Local Government and the Provincial Cabinet (PGWC) did not approve the Health Services Task Team's recommendations. The important question, then, is why did the provincial cabinet not approve the recommendations to commence the transfer of PHC services to the City of Cape Town? Senior provincial health official (2) offers two reasons: the cost of transferring primary health care services to the City of Cape Town municipality was too high for the PGWC, and there was no legislative framework to support the transfer.

The financial argument is that the PGWC could not afford to transfer its component of personal primary health care services to the municipality. This is a feasible argument when one considers the type of decentralisation that was envisioned. The type of transfer was going to have to be delegation, which required that the Department of Health (PGWC) transfers management responsibility and funding over to City Health. In effect, transferring management responsibility would mean that City Health would be responsible for those managers who would be transferred from MDHS. Furthermore, the health personnel in the facilities would have had to be transferred and their salaries, pension and other payouts would represent a huge financial burden, which the PGWC health budget could not carry. It would appear that delegation was the Department of Health's (PGWC) preferred option, but the Provincial Treasury expected a transfer where the PGWC would not be responsible for funding the services and therefore they would also not be accountable for the service.

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<sup>77</sup> Interview with senior provincial health official (2) at the Department of Health (PGWC) 11 January 2006.

The argument that the legislative framework for the transfer was absent is an interesting one, because there was existing labour legislation that referred to staff transfers. According to IMATU official (1), the Labour Relations Act makes provision for transferring staff from one agency to another without changing the salaries and conditions of service of the staff being transferred.<sup>78</sup> The IMATU official (1) referred to this type of transfer as the transfer of a going concern.

Senior provincial health official (1), who was also involved in these processes, made similar technical arguments when explaining why the transfer did not occur. In addition, senior provincial Health official (1) mentioned another problem, which was whether the PGWC would be able to maintain financial accountability when they transferred funding to a separate authority over which the PGWC has no authority.<sup>79</sup> This was the situation at the time, as the Department of Health (PGWC) was transferring funding to City Health with the MDHS as the overseeing agency.

An interesting point about why the transfer was stalled requires some further discussion. Senior provincial health official (1) noted that implementing the transfer was stalled because the national government had defined municipal health services as environmental health services.<sup>80</sup> In 2002 when the national Minister of Provincial and Local Government, Mr Mufamadi (2002), defined municipal health services, a long-standing issue about the health functions of the respective spheres of government was clarified. The implication of this definition, according to senior provincial health

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<sup>78</sup> The Transfer of staff to municipalities (1998) is another act that makes provision for transferring staff from provincial governments to municipalities.

<sup>79</sup> Interview with senior provincial health official (1), 72.

<sup>80</sup> Interview with senior provincial health official (1), 72.

official (1), was that the nine provincial governments were responsible for primary health care services, while the specified municipalities were only responsible for environmental health services such as water and sanitation services. So the argument was that primary health care services were not transferred because of a national policy decision taken in 2002.

Those outside the provincial health policy system offered other reasons why a transfer of primary health care services to the City of Cape Town did not take place. Senior City Health manager (1) argued that the PGWC did not want to give up power.

Power corrupts and absolute power corrupts absolutely. People don't want to give up power, I think. That and there was, well, the new health act was starting to say that it was going to be a provincial responsibility... but it really is about if you control all the power, you know that's why I say I think it's such a bad decision it was made in that national, you know MinMec... which has the national minister, nine MECs from province and one SALGA rep.<sup>81</sup>

Another important point in this quote is the issue of power within a health policy decision-making context. Senior City Health official (1) notes that the MINMEC, a national body composed of the nine MECs from the provincial governments and the national health minister, decided to associate primary health care services with provincial governments. This is an important point, because it highlights the relative power dynamics between the municipalities and the provincial governments at these national-level health policy meetings. This is related to differences in the level of representation. According to senior City Health official (1), the South African Local Government Association (SALGA), which represents municipalities in South Africa,

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<sup>81</sup> Interview with senior City Health official (1), 56.

has only one individual representative at the health MINMEC.<sup>82</sup> There are 284 municipalities in South Africa and SALGA represents the majority of them. Thus while all provincial governments are represented separately at the health MINMEC, the municipalities have only one voice. Effectively all policy decisions within the health MINMEC will reflect the provincial governments' and the national minister's preferences.

Those who developed the National Health Act (Republic of South Africa, 2004) included only a definition of municipal health services, which meant that other health services became a joint health function of provincial governments and national government. However, the MINMEC preference for provincial governments to run primary health care services is particularly problematic, considering that the national health policy vision was to have primary health care services managed through a DHS and run by a single local government authority as the central focus of a health system. The important point is that the provincial and national politicians who were responsible for health policy were offered a picture that was quite contrary to the one that national Department of Health officials painted in the "Guidelines for functional integration" (Pillay, *et al.*, 2003). The guidelines suggest that the national government wanted a functionally integrated, municipality run district health system (Pillay, *et al.*, 2003).

In summary, the PGWC Cabinet decided to adopt the recommendation of the Bi-Ministerial Task Team that municipalities should be responsible for the DHS. The issue of governance seemed to be partly resolved. The PGWC Cabinet then decided that an initial transfer would occur only to the metropolitan municipality, the City of Cape

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<sup>82</sup> Interview with senior City Health official (1), 56.

Town. However, the only implementation activity that actually took place was the planning for the transfer. As indicated earlier when describing the policy decision that would have begun decentralisation of health service delivery, different actors in the public health sector in the Western Cape Province offered various reasons why the planned transfer did not occur. Senior health managers within the PGWC offered technical and political reasons to explain this stalled implementation. A senior City Health manager attributed the stalled implementation to a power struggle – those with the power did not want to transfer to a municipality and so cede power. Furthermore, the senior City Health manager discussed the relatively lesser power of municipalities compared to that of provincial and national politicians responsible for health to explain why primary health care services were linked to provincial governments. Collectively, these explanations point to reasons why the PGWC Cabinet did not accept the Health Services Task Team's recommendations and thus prevented the actual transfer from happening.

The reasons offered provide one part of the story of why the transfer did not take place. The other part of the story becomes clearer in the next section, when I discuss another important PGWC policy decision, the decision to adopt HealthCare 2010 as the new service delivery framework for the Western Cape Province.

#### **4.4 Policy decision 2: HealthCare 2010 is adopted**

At the end of the financial year in 2002 the Provincial Department of Health adopted a strategic plan, HealthCare 2010, to deal with issues related to health service delivery in the Western Cape Province (Western Cape DoH, 2003: 6, 7). This was only a short time after the Health Services Task Team, which was charged with examining transfer

options, had developed a final draft report in July 2002. This report still recommended a phased transfer of primary health care services to the City of Cape Town municipality.

The arguments from the interviews with the provincial health policy actors suggest that primary health care services could not be transferred to the City of Cape Town because of predominantly technical reasons. However, the presence of HealthCare 2010 suggests that within the Department of Health (PGWC) new plans were being made about how health service delivery should be provided in the Western Cape Province. These plans did not refer to any form of a transfer of primary health care services between the PGWC and the municipalities in the Western Cape. The focus of health system reform in the Western Cape Province shifted away from issues of governance and functional integration through intergovernmental transfers to reorganising the provincial government's responsibilities for health services.

This initiative to reorganise the way that the health system operates in the Western Cape Province came solely from the Department of Health (PGWC). HealthCare 2010 was first tabled before the Provincial Cabinet in 2002. The Provincial Cabinet advised the provincial health department to consult with stakeholders on the new plan for health service delivery. The municipalities in the province were included as important stakeholders because of their role in providing primary health care services, which were the central focus of health service delivery reform. Municipalities throughout the Western Cape Province were still providing one part of primary health care services at that time. The Provincial Cabinet adopted HealthCare 2010, a new provincial strategy for health service delivery for the entire Western Cape Province in March 2003.

There are three important questions to address in the following discussions. First, what did HealthCare 2010 propose as the new framework for health service delivery and how did this relate to national health policy expectations such as implementing functional integration and a DHS in the province. Second, how was HealthCare2010 justified? It is important to discuss the justifications because they suggest a logic that informed the policy decision. I will unpack various logics in the analytical chapters to demonstrate the value of analysing the language of arguments when studying public policy implementation. Third, how was HealthCare 2010 implemented in the metropolitan municipal area after March 2003?

#### *HealthCare 2010*

The Provincial Cabinet approved the conceptual framework for HealthCare 2010 in September 2002 (Western Cape Department of Health, HC2010, 2003: 12), but they asked that stakeholders be consulted about it. In March 2003 the Provincial Cabinet approved “the broad framework of HealthCare 2010 and its implications for the delivery of health care within the Western Cape” (Western Cape Department of Health, HC2010, 2003: 12) and it was this that the provincial government formally approved for implementation from March 2003 onward.

HealthCare 2010 “proposes that patients be treated at the lowest appropriate level of care in order to obtain the optimal benefit from the Department’s limited budget” (Western Cape Department of Health, 2003a). It proposes that health service delivery in the province be restructured in the following way: “90% of patient contacts should occur at primary level, 8% at secondary level and 2% at tertiary level”. This means that

ninety percent of health services in the province would be provided in community health centres, clinics and district hospitals, while ten percent of health services would be provided in secondary and tertiary hospitals. Furthermore, it was envisioned that referrals would occur within the restructured health system. This meant that those patients who report at primary health care centres, but need secondary level care, would be referred upward to hospitals and the same will apply if someone reports at the secondary-level care facility first, but can be treated at a primary health care facility.

The restructuring would have been in line with national policy expectations because the restructuring would change the health system focus from curative health services to primary health care services where curative, preventative and health promotion services are integrated. Furthermore, the restructuring would have facilitated access to health care services. Primary health care facilities are located in the communities that they serve, whereas hospitals are not that widely distributed throughout the Western Cape Province. In the metropolitan area, however, there are seventeen hospitals and another two have been planned: one for Mitchell's Plain and one for Khayelitsha (Western Cape Department of Health, 2004: 13). Some of the hospitals offer specific services such as rehabilitation services and therefore are not all accessible for any type of patient.

Notwithstanding such consistency with national goals, HealthCare 2010 in the Western Cape Province diverted the emphasis of health system reform from creating a DHS to implementing a new provincial health service delivery plan. There is evidence suggesting that developing a DHS is no longer an important provincial health policy goal. First, the HealthCare 2010 document does not refer to a DHS as the management

system for this health service delivery framework. In the HealthCare 2010 document the word ‘district’ is used to describe a type of hospital. Second, the HealthCare 2010 principles are “quality of care at all levels, accessibility of care, efficiency, cost effectiveness, primary health care approach, collaboration between all levels of care and de-institutionalisation of chronic care” (Health Western Cape, 2003: 14). There is no mention of a decentralised management system, organised according to nationally defined health districts, although the health districts are defined and identified in the National Health Act (Republic of South Africa, 2004: 38). They coincide with the metropolitan and district municipality boundaries.

In the absence of any mention of the DHS in the Western Cape Department of Health’s restructuring plan, it is important to ask whether the department is still committed to establishing a DHS in the Western Cape Province. This is an important question, which I will address throughout the discussions in this chapter and the following chapters.

#### *Justifications for HealthCare 2010*

I examined three Western Cape Department of Health documents to identify the logic behind HealthCare 2010, namely “The case for change! A brief introduction to HEALTHCARE 2010, a conceptual framework for change” (October 2002); the Western Cape Department of Health’s annual report for the financial year from 2002 to 2003; and HealthCare 2010, the plan for restructuring the provincial health system, which the PGWC Cabinet approved in March 2003. Each of these documents highlights HealthCare 2010 as the solution to the following problem: how could the Western Cape Department of Health continue to provide a quality health service and increase access to health services while provincial health funds were decreasing?

In making the argument for change, the Western Cape Health Department notes that its leadership “accepts that the service must be reshaped, reengineered and reprioritized if it is to meet the needs of the Province by 2010” (Western Cape Department of Health, 2002: 1). The reasons for change extend beyond the department seeking to deliver quality services within the limits of the health budget. Specifically mentioned is that people and health professionals are not satisfied with the service, that HIV/AIDS is likely to affect health services in the province, that the resources for health service delivery will decrease because, among other reasons, the national government envisions decreasing the conditional grant for specialised tertiary health services, that there has been a duplication of services, and some of the infrastructure for health service delivery is no longer suitable. The final reason given is that there would be a significant discrepancy between the operating budget they envisaged having in 2010 and their projections of what health services delivery would cost in 2010 (Western Cape Department of Health, 2002: 1-3).

The 2003 Western Cape Department of Health Annual Report noted that HealthCare 2010 is the solution to the problem of increasing demand for health services in the context of decreasing provincial government resources (Western Cape Department of Health, 2003a: 6). It referred specifically to a decrease in the National Tertiary Services Grant as a reason why the provincial government’s health funding was lower (Western Cape Department of Health 2003a: 6). The South African national government provides conditional grants to provincial government and municipalities in addition to the general grant that they receive. The National Tertiary Services Grant provides funding to provincial governments to manage and provide health services in tertiary

hospitals. The report also notes that a weak rand created an additional funding dilemma in terms of the costs of medicine (Western Cape Department of Health 2003a: 6). In addition to a scenario of decreasing finances, the report notes that TB, HIV/AIDS and trauma place a huge burden on health services (Western Cape Department of Health 2003a: 6). In these circumstances the conclusion was that the Western Cape Department of Health had no other option but to plan a restructured health service to address these pending problems.

The Western Cape Department of Health should have expected a decrease in the conditional grant for hospital services, because national health policy makers had emphasised that health system reform meant prioritising primary health care services. In practical terms this meant that provincial governments had to spend more on primary health care services, which are primarily offered in province-run community health centres and municipality-run clinics. In other words, the national government expected provincial governments to allocate more of their grants from the National Treasury towards funding primary health care services. This required provincial governments such as the PGWC to make a substantial mind shift away the apartheid-era health system, which emphasised hospital-based services, which were the primary responsibility of the provincial government.

The PGWC would have needed a significant increase in its budget to take over responsibility for personal primary health care services. In 2001/2002 the PGWC transferred R187 646 000 to the municipalities for non-hospital primary health care services, while the contribution from local government for non-hospital primary health care services amounted to R234 167 000 (Thomas *et al.* 2004: 10). The Western Cape

Department of Health would need additional funds equivalent to municipalities' contributions to primary health care services to take over these services, unless they cut the costs of providing public health services in the Western Cape Province.

The core argument that these documents support is that the Western Cape Department of Health had no other option but to change how health service delivery was provided in the Western Cape Province. As decreased funding for health service delivery was always given as a major justification for the proposed changes, it is therefore important to explore this dimension. Why would the provincial health department think that it would not be able to afford health service delivery in 2010? The answer lies in a national policy decision taken in October 2002, which clarified which sphere of government was responsible for what particular health services. The national government had decided that municipal health services mean environmental health services.<sup>83</sup> Environmental health services refer to “water-quality monitoring; food control; waste management; health surveillance of premises, surveillance and prevention of communicable diseases except immunisations; vector control; environmental pollution control; disposal of the dead and chemical safety” (Republic of South Africa, 2004: 14). By clarifying the health services that municipalities were responsible for, the Act by implication indicated the boundaries of the national and provincial governments' health service responsibilities.

However, the timing of the proposal of HealthCare 2010 to the PGWC Cabinet and the timing of the national policy maker's announcement on the meaning of municipal health services suggests that the two events are related. The definition of municipal

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<sup>83</sup> Ministers Authorisations to Category B municipalities for water, sanitation, electricity and municipal health in terms of the Municipal Structures Act (as amended) 2000, 7 November 2002. <http://www.info.gov.za/speeches/2002/02111814461004.htm> (19/11/06).

health services was announced in 2002 and Healthcare 2010 was proposed to the PGWC Cabinet in 2002. If one considers that provincial and municipality politicians and senior provincial government officials interact through intergovernmental forums, then it is probable that HealthCare 2010 was the Western Cape Department of Health's response to their anticipated health service responsibilities. Senior provincial health official (1) noted that they interpreted the announcement that municipal health services covered environmental health as also indicating that provincial governments were responsible for primary health care services.

The announcement of municipal health services as environmental health services did not mean that the national government favoured the provincialisation of personal primary health services as a long-term goal.<sup>84</sup> In the National Health Act (Republic of South Africa, 2004: 42) under the title "Health Services to be provided by the municipalities", provision is made for a provincial Member of the Executive Council to decentralise health services to a municipality. The circumstances under which such a transfer can be made are defined in section 156 (4) of the Constitution (Republic of South Africa, 1996: 84): "the national government and provincial governments must assign to a municipality, by agreement and subject to any conditions, the administration of a matter listed in Part A of Schedule 4 or Part A of Schedule 5 which necessarily relates to local government", provided the municipality has the capacity and the matter is considered to be best administered by a municipality. The National Health Act (Republic of South Africa, 2004: 42) notes that the agreement referred to in the

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<sup>84</sup> In a background paper prepared for the Gauteng provincial and municipal authorities Barron (2005: 3) notes that the definition of municipal health services means that personal primary health services have become a provincial responsibility. However, Barron noted that the key matter that the Gauteng authorities had to decide on was "Should PPHC services be managed by the GDH (provincialisation) or should they be managed by the COJ (decentralisation)?" (Barron, 2005: 4). Gauteng is another province in South Africa. COJ refers to the City of Johannesburg, which is a metropolitan municipality. GDH refers to the Gauteng Department of Health.

Constitution is a service-level agreement. Its presence suggests that the National Health Act (Republic of South Africa, 2004) promotes delegation as the form of decentralisation for the health sector.

*Implementing HealthCare 2010 in the metropolitan area*

The main implementation activity associated with HealthCare 2010 in the metropolitan area was developing the strategic planning document for implementing the new health service delivery plan that it contained. In September 2003 a MDHS Task Team under the leadership of its Director, Dr Bitalo, released a Strategic Plan for the period 2004 to 2007. The strategic plan would be the basis for implementing Healthcare 2010 (MDHS, 2003: 3). The Foreword to this document indicated that the first strategic planning session occurred in August 2003, when a task team was convened to develop the strategic plan (MDHS 2003). The task team was intergovernmental in that it included persons from MDHS, the Department of Health (PGWC) and the City of Cape Town municipality (MDHS Strategic plan, 2003: 3).

An important point about implementing HealthCare 2010 in the metropolitan area was that its implementation, through the health service delivery plan, was noted as being subject to two conditions in particular. The one condition was that implementation of HealthCare 2010 would be subject to the cooperative framework agreement between MDHS and City Health (MDHS, 2003). The second condition was that implementation based on the strategic plan would also be subject to the amalgamation of district health services into a unified DHS (MDHS, 2003). In effect, then, the strategic plan was indicating that the implementation of HealthCare 2010 in the metropolitan municipal area was subject to the conditions of the relationship between the two organisations

running primary health care services in that area. Furthermore, this strategic plan suggests that the implementation of the Western Cape Department of Health's policy initiative, which the PGWC Cabinet had approved in 2003, was being made subject to implementing a national health policy goal, which is creating a DHS.

It is significant that the DHS was not mentioned in the Healthcare 2010. The national government had promoted the DHS as the management system that would facilitate building a health system that links health planning to people's needs within each health district. The absence of a reference to the DHS suggests that one should ask about the kind of health system reform that Healthcare 2010 would facilitate. Healthcare 2010 set out to alter the health system by integrating the system through a hierarchical system of access to health services.

As noted above, HealthCare 2010 did not mention a DHS. This is significant because building a district health system has been a fundamental goal of health system reform in South Africa. However, the MDHS strategic planning document (MDHS, 2003: 9) indicated that in the metropolitan municipal area a unified District Health System was one of the priorities. It is unclear what exactly a unified DHS means in this context.

The strategic plan refers to a number of issues affecting its implementation. The strategic plan notes that when the Health Bill was passed, it would guide the political processes regarding the establishment of a unified DHS (MDHS, 2003). The National Health Act would affect the strategic plan for implementing Healthcare 2010, because it had implications for the funding and governance of "district-level health services" (MDHS *et al.*, 2004: 6). The strategic plan was being developed as the national health

bill was still moving through the legislative process. Thus the response in the strategic plan was based on the National Health Bill, in which they saw that primary health care services would be declared a provincial competence, because municipal health services would be defined as environmental health services (MDHS *et al.*, 2004: 6), which means that the provincial governments would become responsible for the DHS.

As described earlier, if the provincial government became responsible for primary health care services, they would be obliged to take over the costs of all health services except environmental health services. Senior City Health manager (1) pointed out that some municipalities had indeed indicated that they were no longer willing to fund primary health care services.<sup>85</sup>

If the PGWC did want to take over primary health care services they would struggle to afford the cost associated with fully funding primary health care services in the metropolitan area. In fact, the provincial government's argument was that it was unable to transfer primary health care, because it could not carry the full costs of these health services. The City of Cape Town municipality agreed to continue making its financial contribution to primary health care services, when the provincial government had in fact stated its intention to take over primary health care services from municipalities in November 2003. The reason why the City of Cape Town continued their contribution remains unclear. However, in terms of HealthCare 2010, the important point was that the implementation of this strategy plan would be dependent on whether City Health agreed with the implications of the new service delivery plan.

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<sup>85</sup> Interview with Senior City Health official (1), 56.

The MDHS annual reports from 2004 to 2006 do not indicate that there were any major undertakings to implement Healthcare 2010 in the metropolitan area beyond developing the strategic plan. One reason could be that the costs of transferring the provincial component of primary health care services to the City of Cape Town were considered too high, but it is unlikely that the PGWC would take over the services that the City of Cape Town municipality provided because this would have been unaffordable.<sup>86</sup> Indeed the MEC for Health, Mr Pierre Uys, noted in March 2005 that the PGWC could not take over primary health care services in the metropolitan area because they could not afford to do so. However, the press release does indicate that the PGWC's intention is to take over personal primary health care services in all municipalities. Furthermore, if MDHS and City Health officials had stuck to their conditions for implementing HealthCare 2010 through the joint agreement between the two bodies, one could have expected that the context for health service delivery had not changed in the metropolitan area since the strategic plan developed in 2003.

#### **4.5 Policy decision 3: the provincialisation of PPHC services is initiated**

Apart from the adoption of Healthcare 2010, the Western Cape Department of Health's 2004 annual report highlights another significant health policy decision. The policy intention was that the PGWC would take over personal primary health care services from all municipalities in the Western Cape Province (MDHS, 2004: 2). The Western Cape Department of Health's Annual Report (2004a) does not indicate who took the policy decision. In the annual reports submitted after 2003 the justifications supporting the decision to provincialise personal primary health care services suggest that it was a PGWC Cabinet decision.

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<sup>86</sup> Interview with senior provincial health official (1), 72. Interview with senior provincial health official (2), 77.

In the Department of Health's 2004 annual report there are a number of justifications to defend provincialisation (Western Cape Department of Health, 2004a: 13). One was the long-standing issue of governance over the DHS. Under the heading "Programme 2: District Health Services" it is noted that "Following exhaustive attempts to resolve the issue around District Health System governance, the decision was taken to provincialise municipal personal primary health care services" (Western Cape Department of Health, 2004: 13). This decision was reached following a proclamation by the Minister for Provincial and Local Government, Mr Mufamadi, which confined Municipal Health Services to environmental health services.<sup>87</sup> Another justification maintains that there was a need for health services integration and for more effective health service delivery (Western Cape Department of Health, 2004a: 13). These justifications offer little information as to the coherent logic that informed this decision. However, senior provincial health official (1) offers more insight into why this decision was taken:

We told them that in 2003 the line was drawn when you made the definition of municipal health services, same time they promulgated that Municipal Finance Management Act and the... Act makes it clear that no local government can use ratepayers' money to fund a function that they are not accountable for... it's a funding issue.

According to this justification, the decision was based on an interpretation of the implications of two policy decisions. The one policy decision was the definition of municipal health services and the other was the finance legislation that regulated how municipalities spend their money. The argument which senior provincial health official

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<sup>87</sup> Ministers Authorisations to Category B municipalities for water, sanitation, electricity and municipal health in terms of the Municipal Structures Act (as amended) 2000, 7 November 2002. <http://www.info.gov.za/speeches/2002/02111814461004.htm> (19/11/06).

(1) makes is that the decision to provincialise was based on the fact that municipalities were only legally responsible for environmental health services and therefore they could not contribute funds for personal primary health care services as they had done for some time. In other words, the PGWC had to fund personal primary health care services on its own and thus the PGWC Cabinet decided to take over these services from the municipalities.

The interesting point to note is that the PGWC Cabinet both approved HealthCare 2010, and decided to take over personal primary health care services from municipalities in 2003. The two decisions were not linked, even though provincialising personal primary health care services would significantly facilitate implementing HealthCare 2010. For example, if the PGWC took over personal primary health care services, then the Western Cape Department of Health would be responsible for all the health services that HealthCare 2010 referred to. This would have meant that the provincial health department need not negotiate implementation with municipalities.

The PGWC Cabinet decision to take over primary health care services was relevant for the entire Western Cape Province. The decision to provincialise PPHC services was implemented in the non-metropolitan area of the Western Cape Province from November 2003 onward and the activities around this implementation are the subject of the next chapter. The decision to provincialise had not been applied in the metropolitan area between 2003 and April 2006, which is when I was conducting fieldwork. When the MEC for Health, Mr Pierre Uys, announced the decision to provincialise personal primary health care services in March 2005, he also noted that the PGWC would only take over these services in the metropolitan area when they could afford to do so

(Western Cape Department of Health, 2005a). Thus until the Western Cape Department of Health takes over these services from the City of Cape Town municipality, implementing HealthCare 2010 in the metropolitan area would be an intergovernmental initiative and a collaboration between MDHS and City Health.

#### **4.6 Conclusion**

This chapter discussed the implementation of health system reforms related to establishing a DHS in the metropolitan area of the Western Cape Province. I began with a description of health system fragmentation and the attempts implemented in the metropolitan area to remove fragmentation. Through this research I identified three strategies that were adopted to integrate preventative, health promotion and curative health services in primary health care facilities. These strategies were important, because they were attempts to give effect to a national policy directive to implement functional integration. While the strategies for health service integration was an important step when implementing functional integration, the effect of primarily the first strategies, full integration and minimal integration, were limited due to inter-agency conflict within these health facilities. An important point was that the third strategy, single-authority integration, was adopted as a response to inter-agency conflict and it was to be applied only in those health facilities where conflict affected service delivery.

The other important aspect about functional integration was that the health management agencies in the metropolitan area collaborated in different forums regarding how health service delivery would occur in the metropolitan area. The important point from this section was that the relationship that existed between MDHS and City Health complied

with functional integration expectations.

In this chapter I discussed three important policy decisions: the 2001 decision to transfer personal primary health care services to the City of Cape Town, the adoption of HealthCare 2010 in March 2003 and the 2003 PGWC Cabinet decision to provincialise personal primary health care services. The 2001 decision would have initiated decentralisation of primary health care services, albeit only in one health district, but it was never implemented beyond the planning phase. I discussed reasons from different actors within the provincial health policy sector as to why implementation did not proceed past the planning phase. Senior provincial health officials offered mainly technical and financial reasons, while senior municipality officials in the City of Cape Town mentioned that the PGWC feared losing power and therefore primary health care services were not decentralised.

An important explanation for why the decision to decentralise primary health care services was not implemented was that those within the provincial administration, particularly the Western Cape Department of Health and Provincial Treasury, did not agree on the type of decentralisation that should occur. The type of decentralisation that would be implemented was no trivial matter, because it was related to matters of financial accountability. The two competing positions were, first, to initiate a decentralisation process that would lead to transferring the personal primary health care services function to municipalities. The second was to contract the delivery and management of personal primary health care service delivery out to municipalities. The provincial health managers' explanations suggest that Western Cape Department of Health preferred not to transfer personal primary health care services to a municipality.

The Western Cape Department of Health developed HealthCare 2010 to restructure health service delivery throughout the Western Cape Province. This plan included health services over which it had no authority. But this situation was soon to change with the PGWC cabinet decision to take over personal primary health care services from the municipalities in the Western Cape Province. An important point about HealthCare 2010 and the PGWC decision to provincialise personal primary health care services was that the latter decision facilitated the implementation of HealthCare 2010. The Western Cape Department of Health then needed to negotiate with municipalities about funding for personal primary health care services. It also needed to co-ordinate service delivery in various municipality-run facilities. HealthCare 2010 was only implemented in the metropolitan area to the extent that there was a joint task team that developed a strategic plan for implementation in this area. The significant point here was that the strategic plan indicated that implementing HealthCare 2010 was subject to an existing agreement between MDHS and City Health, the health management agencies who plan for health service delivery in the metropolitan area. One may extrapolate from the conditions they set for implementing HealthCare 2010 that not much had happened beyond planning, as issues related to creating a unified DHS still needed to be resolved. The issues were likely to be resolved only when the Western Cape Department of Health had the funding to take full responsibility for personal primary health services in the metropolitan municipal area.

Provincialising personal primary health care services meant that the PGWC would take over these services from municipalities. The PGWC thus became the single authority responsible for the health services provided in health districts. This is a reversal of the

earlier policy intention to decentralise personal primary health care services to the City of Cape Town. Furthermore, it suggests that the PGWC is no longer considering decentralising personal primary health care services. The policy decision to provincialise personal primary health care services was not applied in the metropolitan municipal area as the PGWC could not afford to take over these services.

The policy decision to provincialise personal primary health care services was implemented in the non-metropolitan area of the Western Cape Province and the decisions and activities related to this are discussed in the next chapter.

## **Chapter 5: Creating a DHS in the non-metropolitan municipal area**

### **5.1 Introduction**

Health system reform took a different turn in the non-metropolitan area. There were no attempts to integrate PHC services into health facilities as was the case in the metropolitan municipal area. Instead the municipalities in the non-metropolitan area continued to provide health services on behalf of the PGWC. In the first section of this chapter I describe the nature of health service delivery in the non-metropolitan municipal area before November 2003.

November 2003 was a significant turning point in terms of health system reform in the non-metropolitan area. The decision to provincialise PPHC services was announced. The provincialisation of PPHC services would mean that health service integration would not follow the lines of functional integration as described in the National Department of Health's Guidelines for functional integration (Pillay *et al.*, 2003). In section two of this chapter I discuss the significant policy decision to provincialise PPHC services in the Western Cape Province. I offer brief insights into how the provincialisation of PPHC services came to light.

Section three documents what happened after November 2003 when the provincialisation of PPHC services was meant to begin. The first theme is the conflict within the intergovernmental task team that was meant to plan for implementation. The second key theme is the activities undertaken to implement the provincialisation of PPHC services, while the decision to provincialise PPHC services was being contested.

This chapter concludes with a summary of the main features of health system reform activities in the non-metropolitan municipal area and a brief introduction to Chapter 6.

## **5.2 Health system fragmentation in the non-metropolitan area**

Fragmentation of health service delivery and health management is more complicated in the non-metropolitan municipal area, where there are 29 municipalities. The five district municipalities, Cape Winelands, Eden, Overberg, West Coast and Central Karoo, each constitutes a health district. Then there are 24 local municipalities. Each district municipality has a number of local municipalities within its jurisdictional boundaries.<sup>88</sup>

Within these health districts, primary health care service delivery is essentially split between the Western Cape Department of Health and the municipalities, with services provided separately and in different types of health facilities. The Department of Health (PGWC) runs its mainly curative health services in community health centres and hospitals. The 29 municipalities provide predominantly prevention and health-promotion services in clinics and mobile clinics in their geographical areas of jurisdiction. For example, the Cape Winelands District Municipality provides preventative health services, control of communicable diseases, TB care and treatment, HIV/AIDS and other STD care, reproductive health care, maternity and neonatal care, child health care, mental health care, and care of the chronically ill (CWDM, 2005b:

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<sup>88</sup> Eden District Municipality has Kannaland, Langeberg, Mossel Bay, George, Outshoorn, Plettenberg Bay and Knysna Local Municipalities in its geographical area. Central Karoo District Municipality has Laingsburg, Beaufort West and Prince Albert Local Municipalities in its geographical area. West Coast District Municipality has Matzikama, Cederberg, Bergrivier, Saldanha Bay and Swartland Local Municipalities in its geographical area. Winelands District Municipality has Witzenberg, Drakenstein, Stellenbosch, Breede Valley, Breede River/Winelands local municipalities.

69). The Cape Winelands District Municipality offers these services on an agency basis to the Western Cape Department of Health (CWDM, 2005b: 69).

Health services management is also separate. The Department of Health (PGWC) manages health services in this area through regional health management offices. Under the Chief Directorate: District Health Services there are three regional health management offices that oversee health services in the non-metropolitan area. These regional health management offices are Boland/Overberg, Southern Cape/Karoo and West Coast/Winelands. The Boland/Overberg directorate offices are in Worcester and the Southern Cape/Karoo offices are in George.<sup>89</sup> The West Coast/Winelands directorate manages provincial health services provision in local municipalities such as Stellenbosch Municipality and in the Cape Winelands District municipality area. The West Coast/Winelands directorate office is located in Malmesbury.<sup>90</sup>

The provincial health management system is based on regions rather than on health districts. The West Coast and the Winelands are two separate district municipalities in the Western Cape Province, but the West Coast/Winelands Directorate in the Western Cape Department of Health manages health services in the geographical area of both district municipalities. The National Health Act (Republic of South Africa, 2004: 38) identified district and metropolitan municipality boundaries as health district boundaries. The Western Cape Department of Health's regional health management directorates thus manage at least two health districts. This means, for example, that the West Coast/Winelands Directorate manages primary health care services with the Cape

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<sup>89</sup> Information from Cape Gateway, which is a provincial government initiative that provides online information on provincial and local government in the Western Cape Province. [http://www.capegateway.gov.za/eng/your\\_gov/6080/contacts](http://www.capegateway.gov.za/eng/your_gov/6080/contacts) (09/06/2009); [http://www.capegateway.gov.za/eng/your\\_gov/6086/contacts](http://www.capegateway.gov.za/eng/your_gov/6086/contacts) (09/06/2009).

<sup>90</sup> Cape Gateway, [http://www.capegateway.gov.za/eng/your\\_gov/6094/contacts](http://www.capegateway.gov.za/eng/your_gov/6094/contacts) (09/06/2009).

Winelands District Municipality, the West Coast District Municipality and the ten local municipalities that operate within the boundaries of these district municipalities.

As I was conducting the research on my own, I was unable to collect information on 29 municipalities in this area. I use the Cape Winelands District Municipality as the basis to discuss municipal health management structures in the metropolitan area. The Cape Winelands District municipality has a Department of Community and Developmental Services. The executive director, who runs this department, is responsible for community and health services. Under the executive director there is a specific director for health services. The health services director manages 33 clinics and 26 mobile clinics (CWDM, 2005b: 69).

The same accountability relationship exists between the provincial government's regional health directorates and the municipality health management as between MDHS and City Health in the metropolitan area. Each municipality that provides PPHC services in the non-metropolitan area of the Western Cape Province is accountable to the PGWC regional health management agencies in which they operate, because they receive funding for health service delivery. For example, the Cape Winelands District Municipality provides health services on an agency basis for the Provincial Government of the Western Cape (CWDM, 2005b: 14, 69; WC Department of Health AR, 2005: 4; 14). In the 2004 to 2005 financial year they received R17 406 110 from the PGWC through the West Coast/Winelands Directorate for rendering primary health care services on their behalf. This means that the director for health services and the executive director who oversee this service must report to the West Coast/Winelands Directorate on how they have spent the money.

In the non-metropolitan area primary health care services funding is also fragmented. Both the provincial government and the municipalities contribute funds to primary health care service delivery. For example, in the 2004 to 2005 financial year the PGWC contributed R17 406 110, while the Cape Winelands District Municipality and other local municipalities in the area contributed R864 868 to PHC services provision and management (CWDM, 2005b: 15). However, unlike in the metropolitan municipal area, the PGWC's contribution to PHC services exceeds the contribution from municipalities. The size of the contribution from the PGWC is important as this was highlighted as an important contributor to the anticipated intergovernmental transfer not taking place in the metropolitan municipal area. The issue of the costs of an intergovernmental transfer of a health function will form an important part of a later discussion on the implementation of the provincialisation of PPHC services in the non-metropolitan municipal area and in the analytical chapters that follow this chapter.

In summary, the health system in the non-metropolitan area in the Western Cape Province was also fragmented along various lines: health service delivery, health management and funding of primary health care services between 1994 and 2005. The extent of the fragmentation is more complicated than in the metropolitan area, because there are 29 municipalities in the non-metropolitan municipal area of the Western Cape Province. Some of these municipalities are health service delivery agents for the Western Cape Department of Health and are thus accountable to the regional directorates who oversee these areas. However, these health service delivery agents also contribute funding to primary health care service delivery. These financial contributions are important for maintaining the various types of health services

provided in these areas, where there are additional health challenges such as providing health care for workers on vineyards, who have limited access to health services because of work circumstances and they often work far away from the nearest health facilities.

In the next section I discuss the key policy decision to provincialise PPHC services in the Western Cape Province in the non-metropolitan municipalities. This was an important decision, because it would integrate health service delivery and health management in all of the health districts in the non-metropolitan area.

### **5.3 The provincialisation of PPHC services enters the intergovernmental agenda**

The PGWC Cabinet decided to provincialise or take over primary health care services from the municipalities in the Western Cape Province in 2003. The PGWC was, however, obliged by constitutional requirements set out in the co-operative governance framework in the South African Constitution (Republic of South Africa, 1996) to discuss provincialisation with municipalities. According to Chapter Three in the South African Constitution (Republic of South Africa, 1996: 25-26), the spheres of government are required to “co-operate with one another in mutual trust and good faith” by, amongst other principles, “informing one another of, and consulting one another on, matters of common interest.”

Both authorities had a stake in personal primary health care services, because neither local government nor provincial governments were designated directly as the authority responsible for the primary health care services. The Constitution only refers to municipal health services as a local government function and health services as a

provincial and national government function (Republic of South Africa, 1996: 144, 143). Both authorities had an interest in PPHC services because both authorities provided, funded and managed parts of these health services. Hence provincialisation was discussed at the Cooperative Governance Summit held in November 2003 in Stellenbosch.

In this section I describe how provincialising PPHC services was introduced to municipalities in the Western Cape Province. I then discuss the issue of funding, which was identified as an important factor that would affect the implementation of provincialisation in the Western Cape Province.

#### *The Cooperative Governance Summit in the Western Cape Province*

On 7 November 2003 members of the PGWC Cabinet held a co-operative governance summit at the Stellenbosch Municipality council chambers in Stellenbosch with the municipalities of the Western Cape Province. The meeting agenda indicated that the MEC for Local Government, Mr Dowry, convened the meeting between the PGWC Cabinet members and the municipality politicians (Provincial Government of the Western Cape, 2003).<sup>91</sup> The MEC for Finance, Mr Rasool, was the speaker on the need for developmental government, dealing with division of powers and functions and proposed solutions. The Premier, Mr Marthinus van Schalkwyk, was noted as the main speaker at the meeting. Those invited to the meeting included the executive mayors and municipal managers of the municipalities in the Western Cape Province as well as the

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<sup>91</sup> The meeting agenda is attached to an invitation. The provincial government reference for the invitation is 19/24/1 and it was signed by MEC for Local Government, Mr JJ Dowry on 21 October 2003.

chief executive officer of WECLOGO, the Western Cape Local Government Organisation.<sup>92</sup>

The Cooperative Summit document titled “Motivation, and recommended resolutions for the Western Cape co-operative government summit.”<sup>93</sup> (Hereafter the Cooperative Governance Summit) (2003) describes the summit meeting as a platform to discuss how provincial and local government could cooperate to promote economic development in the Western Cape Province.

The Cooperative Governance Summit document identified three main themes for discussion: developmental government, cooperative governance and powers and functions. Each of these themes referred to a problem that needed to be addressed. The problem associated with developmental government is the income inequality that exists within the province in addition to the lack of economic growth in the Western Cape Province (Cooperative Governance Summit, 2003: 1). The proposed solution was Ikapa Elihlumayo (The Growing Cape), which is a growth strategy for the Western Cape Province (Cooperative Governance Summit, 2003: 2).

Developmental government constitutes the underlying framework that informs growth and development within the Western Cape Province (Cooperative Governance Summit, 2003: 2). In relation to cooperative governance the Cooperative Governance Summit document notes that the provincial and local government need to work together because, amongst other reasons, government activities are complex, with their

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<sup>92</sup> The meeting agenda, 91. WECLOGO circular number 89 of 2003 dated 11 November 2003.

<sup>93</sup> The document does not have an author. I have associated the document with the PGWC because in the municipality response document this document it is referred to as a PGWC document. Furthermore, the way in which the document is written suggests that it is a PGWC document.

concurrent functions and their functions being interrelated (2003: 12). The key problem associated under the power and functions theme was that there were some constitutionally defined national provincial government functions which municipalities were providing on behalf of the PGWC (2003: 13). The noted functions were “Administration and management of libraries”, “Administration and management of museums” and “Rendering of primary and environmental healthcare services” (2003: 13-14). According to the Cooperative Governance Summit document (2003: 17), the provincial government was not in a financial position to take over these functions, but the municipalities and the PGWC would have to find a “pragmatic approach”, which could include an intergovernmental transfer to the provincial government.

The provincialisation of PPHC services is associated with the powers and functions issue. Until 2002 there was no clarity about the respective health functions of the three spheres of government. National and provincial governments were concurrently responsible for health services and municipalities for municipal health services (Republic of South Africa, 1996: 143-144), but neither one of the services were defined. In 2002 the National Minister for Provincial and Local Government defined municipal health services as environmental health services. So at the time of the Cooperative Governance Summit in November 2003 the PGWC and municipalities were already aware of what their respective health functions were. In terms of this definition all health services except the specified environmental health services were provincial and national government competencies.

However, in the Cooperative Governance Summit document PHC services were identified as a provincial government function, but not based on the minister’s

definition of municipal health services. Instead, PHC services were identified as a provincial government function based on research done to establish whether officials from the two authorities perceived a number of functions as a provincial government function or not (Cooperative Governance Summit, 2003). According to the summit document (Cooperative Governance Summit, 2003: 15), the PGWC established a Trilateral Task Team to develop a “sustainable framework” to manage transfers of powers and functions between the provincial government and municipalities in the Western Cape Province. The Task Team identified primary health care services, library services and museum services as uncontested functions (Cooperative Governance Summit, 2003: 15).

The solution to the problem identified – namely that municipalities were providing functions that belong to the provincial government – would be “a pragmatic solution that would be jointly developed” (Cooperative Governance Summit, 2003: 21). The envisioned solution would have to lead to a “restructured, rationalised, right-sized and fundable core of provincialised services on which the Province can rebuild” (Cooperative Governance Summit, 2003: 21).

The goal of the pragmatic solution was already defined in the document. The PGWC intention was thus to take over primary health care services, library services and museums “with the understanding that this will result in the full provincialisation of these functions” (Cooperative Governance Summit, 2003: 21). The Cooperative Governance summit document indicates that the PGWC and the municipalities agreed that by 1 July 2007 there should be clarity on the responsibilities regarding both the contested and uncontested functions, and that each party will accept “full funding,

managerial and operational responsibilities for each function” (Cooperative Governance Summit, 2003: 21). The goal of any joint development solution was thus to ensure that in the end the provincial government would eventually run these services.

*Funding is identified as a problem for an intergovernmental transfer*

One of the main reasons why PHC services were not transferred to the City of Cape Town was the PGWC did not have sufficient funding to give effect to intergovernmental transfer to a municipality. Funding was raised again as an important issue for provincialising “uncontested functions” in the Western Cape Province. However, in this instance the funding problem was that the PGWC did not have sufficient funds to take over “uncontested” functions from municipalities (Cooperative Governance Summit, 2003: 17, 21) based on the costs of the services at the time of the summit. The Cooperative Governance Summit was also a platform where the issue of funding for the PGWC’s takeover of the set functions would be resolved.

There are two reasons why funding a takeover would be a problem for the PGWC. First, municipalities were contributing funds to personal primary health care service delivery and these additional costs would have to be met if the PGWC took over these health services from the municipalities. Second, personnel costs would increase because municipality nurses often earn higher salaries than public sector nurses. From the research that the Health Services Task Team had conducted into the implications of decentralising PHC services to the City of Cape Town municipality, senior officials in the Western Cape Department of Health were keenly aware of the financial implications of an intergovernmental transfer of personnel.

The extra cost of a personnel transfer would to some extent depend on whether the Labour Relations Act was deemed to be operative. According to IMATU trade union official (1), such a transfer, if it were to be done according to the Labour Relations Act, would constitute a transfer of a “going concern”, in which the persons cannot be worse off under the new employer.<sup>94</sup> Bachmann and Makan (1997: 726) noted that the annual salaries for a staff nurse in the public sector in 1993/1994 would have been R20 859, while a local government nurse in the same position would earn R29 400. Based on these figures the PGWC would need an additional R8 541 per nurse whom they took over from the municipalities. Furthermore, if they were to take over the personnel from municipalities, it is probable that there would be two staff nurses receiving different salaries while working for the PGWC. In the previous chapter I noted that integrated facilities did not operate as anticipated because of the differences between the staff, which were the result of the fact that they were working for two separate authorities. One could expect that provincial nurses would argue for salary increases to put them on a par with their colleagues.

The issue of affordability was resolved at the Cooperative Governance Summit by setting a deadline for reducing the costs of these uncontested functions by 50% (Cooperative Governance Summit, 2003: 21). Municipalities were requested to decrease the costs of personal primary health care services, and museum and library services to half of the costs at the time. The PGWC, in turn, committed to similar right-sizing so that they could have the funds to take over the decreased, or “right-sized functions” from the municipalities (Cooperative Governance Summit, 2003).

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<sup>94</sup> Interview with an IMATU trade union official at the IMATU office in Cape Town on 27 March 2006.

In summary, provincialisation was a topic of discussion at an intergovernmental summit in the Western Cape Province. The PGWC and municipality policy makers in the Western Cape Province, meaning respectively the Cabinet and the mayors and councils, agreed that provincialisation would be applied throughout the Western Cape Province. When implemented, provincialisation would address the problem that the responsible authority was not performing some of its functions. PHC services were one of three functions that the PGWC was going to take over from the municipalities in the Western Cape Province. One of the key problems associated with such an intergovernmental transfer was funding. This issue was resolved by both parties agreeing to cut their own spending on, for example, health services to ensure that the PGWC could afford these services.

#### **5.4 Implementing provincialisation in the non-metropolitan municipal area**

In this section I discuss what happened after the November 2003 Cooperative Governance Summit. Three important features characterise what happened after November 2003. First, a restructuring team that would facilitate the provincialisation process was created. Second, the municipalities challenged the idea of provincialisation, in particular in relation to PPHC services. Third, at the same time that provincialisation was being challenged, implementation activities continued.

The following discussion of implementation activities associated with provincialisation of health services is divided into two different periods of implementation. The first period of implementation between November 2003 and March 2005 was associated with the cooperative governance summit. This section demonstrates how implementation can proceed in the face of resistance. This discussion also provides an

insight into the nature of intergovernmental relations in practice. It suggests that cooperative relations only exist in practice as long as there is agreement between a provincial government and the municipalities in the province. Furthermore, it highlights the hierarchical nature of the South African government system, in that the challenge from the municipalities did not constrain the provincial government from implementing provincialisation.

The second period of implementation occurred from March 2006 onward. This was after the MEC for Health and a SALGA councillor announced in March 2005 that the Western Cape Department of Health was taking over PPHC services initially only from municipalities in the non-metropolitan area of the Western Cape Province (Western Cape Department of Health, 2005). This second period of implementation focuses on one implementation activity, namely the planning for provincialisation of PPHC services in the non-metropolitan municipal area. In this discussion one gains an insight into how those involved in implementation of provincialisation of PPHC services understood their role and what this meant for other actors such as municipality trade unions.

*Establishing the Restructuring Task Team to facilitate implementing the provincialisation of the “uncontested functions”*

The provincial takeover of PPHC services in non-metropolitan areas was meant to begin after the November 2003 summit with the establishment of a restructuring team. The PGWC noted that the restructuring team would comprise the heads of the Department of Local Government and the Provincial Treasury, the chief executive officer of the Western Cape Local Government Organisation (WECLOGO) and five

other members from local government (Cooperative Governance Summit, 2003: 22). Municipal managers, function heads and other experts were identified as assistants to the restructuring team. They would serve the team only if required. The restructuring team would be known as the Cooperative Governance Working Group.

The restructuring team was seen as a technical group whose work was to plan the transfer of the identified provincial government functions that municipalities were providing on its behalf back to the provincial government. The restructuring team's mandate was to find ways to "transfer the right-sized functions to the Province at the earliest practical date, which may be no earlier than 01 July 2004" (Cooperative Governance Summit, 2003: 22). In their planning preparations for the transfer the team was tasked with finding pragmatic and fundable solutions and defining the coordination mechanisms, which would ensure that the transfer, management and the operation of these services occurred without much trouble (Cooperative Governance Summit, 2003: 22). On the surface it would appear that the work of the task team implementing the transfer of PPHC services was to be a cooperative venture that was in line with the constitutional expectations regarding intergovernmental relation, which is cooperative governance.

#### *Contesting provincialisation*

The implementation process did not proceed as expected because municipalities in the Western Cape Province contested the legitimacy of provincialisation. Their discontent was expressed in a number of ways. First, Local Government developed a response paper in which it called for a subsidiarity exercise and a review of provincialisation. Second, there were attempts by specific municipalities to engage with the Premier

regarding the issues, including the decision to provincialise PPHC services in particular. Third, the trade unions had initiated legal proceedings. I will discuss each resistance activity in turn and highlight the key issues that were raised.

The municipalities had highlighted their disagreement with the decision about provincialisation in February 2004 through their response paper to the Cooperative Governance Summit document. They argued that the South African Constitution provides for assignment, delegation and agency agreements, not for provincialisation and thus decentralisation should be considered as an alternative (Local Government Discussion Document, 2004: 24). The key request in the Local Government Discussion Document was that the PGWC, together with Local Government, and the local government trade unions, conduct a subsidiarity exercise on PPHC services (2004: 23).<sup>95</sup> The subsidiarity exercise was meant to take place from 1 July 2004 to 30 June 2005. The interim arrangement for PPHC services would be that service delivery continues as before, and even though in principle the PGWC is responsible for funding the services, in practice municipalities could develop individual agreements for settlement with the PGWC (Local Government Discussion Document 2004: 23).

The principle of subsidiarity was one of the main arguments against provincialisation. Powell (2001: 256) notes that the principle of subsidiarity is an idea that had taken root in the United Nations. Paraphrased from Powell's (2001: 256) citation from a UN document (2001), the principle of subsidiary promotes the belief that governance should occur at the lowest appropriate level and task allocation should be based on this principle. According to a legal advisor to WECLOGO, section 156 (4) of the South

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<sup>95</sup> The municipalities requested individual subsidiarity exercises for all unfunded mandates (Local Government Discussion Document, 2004: 23).

African Constitution entrenches the principle of subsidiarity, which means that “the responsibilities for rendering a particular function should as far as possible be allocated to the sphere of government closest to the recipient of the service” (Legal Advisor, 2004: 1)

The main aim of the subsidiarity exercise was to establish whether the constitutional conditions exist for transferring primary health care services to municipalities. The Constitution describes the conditions for a downward transfer in section 156 (4) (Republic of South Africa, 1996: 84). If a matter is related to local government then, first, it would be more “effectively administered locally,” and second, the municipality must have the capacity to administer the matter (Republic of South Africa, 1996: 84). The call for a subsidiarity exercise could be understood as municipalities asking the provincial government to demonstrate that individual municipalities do not have the capacity to take over PHC services in the Western Cape Province. This would have then demonstrated that provincialisation was a legitimate option in the provincial health policy context.

The Legal Advisor described what these provisos in the constitution meant and by implication also indicated the kinds of criteria that would be relevant when judging whether provincialisation is justified. The Legal Advisor (2004: 3) interpreted the provisos in the following way: “necessarily relate to local government” means that “local government dispensation cannot be maintained properly without the matter forming part of the municipality’s powers and functions regime.” Second, “most effectively administered locally” referred to prerequisites for understanding this provision, which are that there should be clarity on the “nature and scope of the matter

to be assigned” and “the degree of the involvement of the municipality in administering the matter and thus rendering the service to the community” (Legal Advisor, 2004: 4). Finally “the capacity to administer” refers to what is needed to apply this proviso. Capacity means “understanding of a municipality’s capacity both in financial and operational terms.” To establish whether capacity exists, precise indicators are needed and these indicators should be based on the nature and scope of the anticipated matter to be transferred.

The provincial contingent of the Working Group was disappointed with the Local Government contingent’s response to the policy decision to provincialise, amongst other things, PPHC services. The chair of the Working Group responded in the following way in April 2004:

It is quite clear that the whole process initially agreed upon, has been turned on its head by this response from WECLOGO...What has now happened, is that the mandate of the Working Group as agreed by the summit has been unilaterally altered and we are now confronted with a [singular] municipal mandate. The working group therefore has no agreed mandate, and this makes the Working Group in effect redundant.<sup>96</sup>

The chairperson noted that when the municipalities submitted the request for a subsidiarity exercise, they were disputing the mandate. The municipalities were now suggesting a new mandate for the Co-operative Governance Working Group through their response in February 2004, when they asked that decentralisation be considered as an alternative to the PGWC taking over certain services. The municipalities were requesting that the Working Group engage in an activity that was not part of its mandate.

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<sup>96</sup> Letter from a senior provincial government official sent to WECLOGO in April 2004 in response to the local government discussion document.

In summary, the municipality contingent questioned whether provincialisation was appropriate in the context of the Constitution, which makes provision for decentralisation. Thus officials from municipalities were challenging an agreed upon position from the Cooperative Governance Summit held in November 2003 to implement provincialisation. What is significant here is that the municipality component of the Working Group and its supporters argued that decentralisation was the legitimate constitutional option and if provincialisation should be accepted then the PGWC would have to demonstrate that the municipalities in the Western Cape Province do not have the capacity to deliver and manage PHC services.

In the next section I discuss what the PGWC did to take over PPHC services, while municipalities continued to contest provincialisation through WECLOGO. I have labelled these activities implementation activities, because they give effect to the decision to provincialise, amongst other things, PPHC services.

*Implementation activity 1: Department of Health (PGWC) fills municipality vacancies*

One of the implementation activities undertaken was that the Western Cape Department of Health was filling health vacancies that existed within municipalities in the non-metropolitan area. There are, however, two different accounts around the filling of these vacant positions. The Cape Winelands District Municipality describes what happened in the following way: “The overriding issue facing this directorate was the pending provincialisation of PPHC. During this process the capacity of the district was severely depleted as province imposed a moratorium on the filling of vacancies on a permanent basis” (CWDM, 2005b: 69).

Evidence indicates that the Western Cape Department of Health had intended to fill vacant municipality positions. Communications between key actors from the side of the municipalities and the PGWC indicate that the Western Cape Department of Health advertised health service positions without engaging with the municipalities.<sup>97</sup> The filling of vacant municipality positions became an issue as municipalities were still challenging provincialisation. WECLOGO sent a letter on 2 April 2004 to a PGWC Head of Department, which challenged the PGWC for taking action to acquire staff within the areas targeted for provincialisation.<sup>98</sup> The letter notes that district municipalities tried to consult with provincial managers and that such consultation was avoided, “while offers are made to local municipalities to fill vacancies on provincial establishments.”<sup>99</sup> This is interesting because both district and local municipalities have health staff. One would therefore have expected that they would approach both types of municipalities.

Engaging with local municipalities rather than with district municipalities or with both municipalities raises two interesting questions. First, one could ask whether this was done to divide municipalities that were challenging provincialisation. The letter from WECLOGO to a PGWC Head of Department notes on the filling of vacant municipality positions: “This would appear to be aimed at pre-empting the outcome of a subsidiarity test and is not keeping with the understanding of the filling of posts” and

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<sup>97</sup> The communications are email communications between health officials (9 and 10 December 2004) within one municipality. They are discussing two emails (7 December 2004) from a regional health management official from the Western Cape Department of Health regarding the filling of vacancies. I have permission from one of the health officials from the municipality to use the email communication.

<sup>98</sup> Letter from WECLOGO to a PGWC head of department dated 2 April 2004. Response from a Head of Department to WECLOGO dated 8 April 2004 notes that the 2 April letter from WECLOGO was received. The response from a provincial government head of department has a government reference 4/5/5/R.

<sup>99</sup> Letter from WECLOGO to a PGWC head of department dated 2 April 2004.

“It is also understand that the Province is advertising posts and making permanent appointments without consulting with municipalities.”<sup>100</sup>

A second question raised is whether talking to local municipalities was a strategy to obtain health staff at lower salaries, because different categories of municipalities have different remuneration scales. As district municipalities are higher-level municipalities it is possible that they have higher salaries for their nurses. For example, senior City Health manager (1) noted that this would certainly be the situation in the metropolitan area because

there’s a grading system in municipalities... if you’re a nurse then you’re a nurse and then do the same work in theory, but if you’re a professional nurse in Cape Town in Blaauwberg versus a professional nurse in Tygerberg, say, particularly you got paid more in Tygerberg than in Blaauwberg because they were level 14, City of Cape Town and Tygerberg were level 14 or 15 and Blaauwberg was a level 11 municipality in that the salary scales were different.<sup>101</sup>

Two PGWC Heads of Departments responded to WECLOGO’s complaint about the actions of provincial government in acquiring human resources. One of the Heads of Departments responded by requesting that other departments in the PGWC consult with local government. On 24 May 2004 a non-metropolitan municipality received a letter from this PGWC Head of the Department dated 19 April 2004, which notes that that filling posts should be done with regional consultation between the province and the municipalities during this time of uncertainty and, if the post is essential, in filling the post they should endeavour to secure shorter-term contracts.<sup>102</sup> This letter was also sent

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<sup>100</sup> Letter from WECLGO to a PGWC head of department dated 2 April 2004.

<sup>101</sup> Interview 2 with senior City Health official (1) at the Civic Centre Cape Town on 22/02/06.

<sup>102</sup> A signed letter was sent from the head of a provincial government department in the provincial administration in the Western Cape Province. The letter was signed on the 19 April 2004 and the provincial government departmental reference for the document is 19/25/1.

a letter to the heads of the Departments of Health, Cultural Affairs and Sport, Transport and Public Works and all municipal managers and executive mayors regarding filling vacancies in health, roads, library and museum services.<sup>103</sup>

In the provincial health context, then, the Western Cape Department of Health did take action to implement the provincialisation of PHC services. The WECLOGO communication to a PGWC Head of Department notes that the Western Cape Department of Health was involved in such an activity. The communications from a provincial health management official to a district municipality health official, which note the intention to fill vacancies if the district municipality health official does not respond, corroborates the claims in the WECLOGO communication.

When the Western Cape Department of Health undertook to acquire additional health personnel from municipalities by advertising municipality vacancies on provincial government conditions of service and salaries, the municipality trade unions were effectively sidelined. Intergovernmental transfer of labour between the municipalities and the affected PGWC departments was also sidestepped and no labour relations process would be needed. This is significant, because problems associated with an intergovernmental transfer of personnel were noted as having affected why the PHC transfer to the City of Cape Town municipality did not take place.

This strategy for taking over human resources, which circumvents the labour relations process for transfers of persons between organisations when the service does not

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<sup>103</sup> A signed letter was sent from a PGWC Head of Department in the PGWC. The letter was signed on the 19 April 2004 and the provincial government departmental reference for the document is 19/25/1.

change, was not new. It had been applied in the Free State Province and IMATU had challenged this action in a labour court. IMATU official (2) describes what happened:

No, it's been completed and it was a case where people were not transferred in terms of 197 [section 197 of the Labour Relations Act] and it's the same debate. It's the provincial government taking the local government. What they did is actually they gave the individuals a few days notice and they said come tomorrow and you won't work for local government, you will work for provincial government on our conditions of service. We took the matter to the labour court,... after the preliminary interdict normally what happens is the court then asks parties to put their arguments why it should be made a permanent interdict and before that actually happened there was a settlement. And the settlement was that they will put the individuals in the position they would have been if the transfer was done correctly in terms of 197. So this was not in opposition to the transfer, it was the fact that the transfer was not done in terms of section 197 of the Labour Relations Act.

IMATU official (2) notes that the strategy would eventually lead to personnel being indirectly transferred from municipalities to the provincial government. This action would be contrary to the expected labour relations process in terms of section 197 of the Labour Relations Act. An interesting point here is that the court did not make a judgement on this case as the parties had settled. The settlement as described suggests that the provincial government had conceded to the municipalities and conducted the transfer in compliance with the outcomes of a labour relations process transfer of a going concern.

IMATU official (2) explained the proper process for a labour transfer when the function is a going concern in the following way: "You still continue doing the same work, the same business then you will not require to authorise your transfer, it will be automatic in terms of the statute." So "the contract of employment transfers automatically to the new employer on the same terms and conditions as what they currently enjoy with the old employer." As primary health services were a going

concern, the transfer from the municipalities in the non-metropolitan municipal area to the PGWC would have been automatic.

It is important to note what a labour relations act transfer would have meant to the PGWC government departments who would be provincialising the identified services, which includes health. In the first instance, transferring a going concern through a labour relations process would have increased the human resources costs for the Western Cape Department of Health, because the department would have to take over municipality staffs, who had higher salaries and different service conditions. This means that if the PGWC had pursued a Labour Relations Act process, then it would have needed additional finances for PPHC services.

Furthermore a transfer based on the Labour Relations Act procedure for transferring a going concern would have produced a situation where, for example, two nurses were working in one health facility, providing the same health services but they would be earning different salaries. IMATU official (1) was involved in the provincialisation of Emergency Medical Services (EMS) and noted that the situation was recognised as a problem when the PGWC took over EMS services from municipalities:

...so employees go over with their conditions of service etc. etc. However,... that's going to create a problem and it has, because the province recognised were going to have two ambulance men working side by side earning different wages, different conditions. They have engaged the unions in an endeavour to reach what is called an alternative agreement, which is also provided for the act. In other words you can reach a collective agreement so that the employees move over to the same conditions of service as the parent authority, and it makes provision for that. Where the union doesn't get a mandate from those persons to be transferred, it's difficult.<sup>104</sup>

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<sup>104</sup> Interview with IMATU official (1) at one of the IMATU offices in Cape Town on 27 March 2006.

In the previous chapter I noted that differences between provincial and local government health personnel had negative implications for integrating health service delivery, because they affect interpersonal relationships. The interesting point which IMATU official (1) notes is that there is space to negotiate an alternative way to transfer staff through a labour relations process, which will reduce the problem of differential salaries and service conditions.

Furthermore, advertising a municipality's health services vacancies, for example, would have left the health staff in clinics in the non-metropolitan area in a precarious position. They would have been informed about the provincial government's intention to take over PPHC services and they would see their posts advertised by the Western Cape Department of Health. They would have had the following options: wait for the Western Cape Department of Health to offer them transfers in accordance with the Labour Relations Act, apply for the advertised positions, or resign and move to the private health sector. A group of nurses at a clinic in the Boland District Municipality took a more proactive approach. On 26 January 2006 a District Municipality director for health services informed the executive director responsible for health services that the PPHC nurses in Robertson had asked that the PGWC should take each staff member over with their individual service conditions.<sup>105</sup>

Taking over health services personnel through advertising PPHC service positions under the provincial government service conditions and salary scales indicates that the Western Cape Department of Health had funds to increase their human resources. This may have been because they had decreased their costs in order to afford to take over

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<sup>105</sup> E-mail communication between senior health officials in a district municipality on 26 January 2006. Reference: 7/2

these services as they had indicated they would in the Cooperative Governance Summit document. However, the 2004 Western Cape Department of Health budget speech indicates an increase in funding to district health services. This funding increase was not related to right-sizing, but it came instead from the National Treasury.<sup>106</sup>

According to senior provincial health official (1), these funds were viewed as a green light for provincialisation; he argued that “Trevor [Manuel, South African finance minister] announced... in 2004 the Treasury has made provision for R300 million escalating over a three-year period to the provinces. Now we interpret that he supports for us to provincialise the service.”<sup>107</sup> The R300 million was the estimated costs that the municipalities in the non-metropolitan areas in South Africa contributed toward PPHC services. This means that the Western Cape Department of Health did not need to readjust its expenses and neither did the municipalities, as the department had the funding to take over the services as they were.

So why did the Western Cape Department of Health not engage in a labour relations process to transfer health personnel from the non-metropolitan municipalities to the PGWC when it had additional funding? Senior provincial health official (1), who commented on the nature of the personnel transfer process, noted that the same method was being applied to provincialise PPHC services as was used to provincialise EMS: “we announce that we are going to provincialise the service because we got from

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<sup>106</sup> Kahn (2004) reported that the National Treasury asked the national health minister to reconsider providing funding for primary health care services in the metropolitan municipal areas. The article notes that the health policy director in the National Treasury noted that it is not certain that taking primary health care provision away from the metropolitan municipalities is the right thing to do and he noted that they are not sure that it is affordable. The Intergovernmental Financial Relations Act (1997: 3) makes provision for establishing a Budget Council, which comprises the national finance minister and the provincial finance ministers. This council is a forum for fiscal and budgetary matters and the provincial governments thus have direct access to lobby the national government for additional funding for provinces.

<sup>107</sup> Interview with senior provincial health official (1), 72.

Treasury R67 million to pay for the staff which we can retain. So we're not taking over the staff."<sup>108</sup> Then senior provincial health official (1) suggested that, because they were not planning to take over the health staff, they were not planning for a Labour Relations Act transfer process for a going concern.

These comments suggest that the Western Cape Health Department was not planning to keep all the PPHC service personnel who were working for the municipalities at the time. Senior provincial health official (1) had indicated that the Western Cape Department of Health had taken over 300 positions from municipalities in the non-metropolitan municipal area.<sup>109</sup> Based on the comments above, we can deduce that this was the number of staff that the provincial government could afford to retain and a decision was taken to increase their number of health personnel without a labour relations process. It is possible that the Western Cape Department of Health was attempting strategically to avoid the implementation difficulties that had cropped up previously when they provincialised EMS and attempted to transfer PHC services to the City of Cape Town municipality.

*Implementation activity 2: Making PPHC services affordable for a PGWC take over*

The Co-operative Governance Summit document (2003: 16) indicated that the provincial government could not afford the uncontested functions. The PGWC and municipalities agreed to right-size the uncontested functions over a period of three years up to a level when it would become feasible for the PGWC to fund the service alone (Cooperative Governance Summit, 2003: 21). Right-sizing meant decreasing the costs of personal primary health care services by 50% (Cooperative Governance

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<sup>108</sup> Interview with senior provincial health official (1), 72.

<sup>109</sup> Interview with senior provincial health official (1), 72.

Summit, 2003: 21). In what follows I discuss what happened in the municipalities and the Western Cape Department of Health in relation to these decreased costs in a single district municipality in the non-metropolitan municipal area.

In light of the stalemate on provincialisation between the municipalities and PGWC contingents of the Working Group, it seemed unlikely that municipalities would voluntarily decrease their costs of PHC services by 50% between 2003 and 2006, despite the Co-operative Governance Summit document. This was indeed the case as, for example, the Boland District Municipality, which had been contesting the decision to provincialise in particular PHC services, had to decrease their PHC services costs by 50%. In 2004 the PGWC cut its subsidy to the Boland district municipality by 50%. In July 2004 the Boland Council, the governing body of the Boland District Municipality, notified the Executive Director for Community Development that the Western Cape Department of Health allocated R12 641 000 towards the R23 million budget for personal primary health care.<sup>110</sup> The Boland Council requested the executive director and the Western Cape Department of Health to outline how the services would be down-sized to accommodate the 50% shortfall in the budget.<sup>111</sup>

The shortfall that the PGWC had anticipated would affect its ability to provincialise PHC services was no longer relevant in 2004, yet the action that was taken to decrease costs was not reconsidered. A District Municipality official noted this because funding was an important argument made in favour of provincialisation:

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<sup>110</sup> Boland District Municipality memorandum (reference: 5/1/1/3-CF). The Boland District municipality is the predecessor of the Cape Winelands District Municipality.

<sup>111</sup> This indicates the Province was implementing its policy of a 50% decrease as outlined in the Governance Summit document in November 2003, even though the extent of the cut was contested by local government (meaning the 29 municipalities in the province) in the Western Cape Province. This reflects the budgetary power of the Provincial Government.

Then when the national budgets came out and in 2004 and it was clear that the funding crisis no longer exists because provinces were given additional funding – increased funding for personal primary health care – then the financial argument disappeared. Now what was also happening in that 2004 period, there was the national elections, April 2004, and so basically local governments and provinces had deadlocked in about February, because local government had responded to this provincial position paper through WECLOGO, which is the local government structure and they had written up the position paper themselves, which stated that they could not support provincialisation unless a proper study had been conducted which proves that provincialisation was the best service delivery mechanism.<sup>112</sup>

The key point here is that the PGWC did not change its position when money was no longer a problem for the provincialisation of PPHC services. During what was meant to be the initial implementation phase of the policy decision, the provincial politicians were involved in the upcoming elections, which suggest that any issues that presented themselves at the time would perhaps only receive attention once the elections were over. The possibility also existed that the policy decision to provincialise PPHC and the other functions could change after the elections in 2004. There was, however, no change in the policy decision after the elections.

This discussion has indicated that it is possible for a provincial government to use the power of the purse to facilitate implementation, particularly when, for example, the PGWC was contributing a substantial amount of the funds that the non-metropolitan municipalities were using for PPHC services.

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<sup>112</sup> Interview with a senior district municipality manager at a non-metropolitan municipality at the Cape Winelands District Municipality offices in Stellenbosch on 20 February 2006.

### **5.5 Implementing provincialisation from March 2005 to end March 2006**

This section documents the implementation of provincialisation of PPHC services in the non-metropolitan area from March 2005 until approximately April 2006. When the National Health Act came into effect in 2005, municipal health services were defined as a specific set of environmental health services (Republic of South Africa, 2004: 14). This narrow definition of municipal health services meant that the provincial and national governments were legally responsible for all personal primary health care services, because they were concurrently responsible for health services in terms of the South African Constitution (Republic of South Africa, 1996). The MEC for Health in the PGWC announced in March 2005 that the Western Cape Department of Health would be provincialising personal primary health care services, but as noted earlier, initially this would only be implemented in the non-metropolitan municipal area (Western Cape Department of Health, 2005b).

From a public policy studies perspective, when a decision has been taken, the assumption is that implementation will follow. We know from the previous discussion, however, that the municipality politicians and the PGWC cabinet members had already agreed on the provincialisation of three uncontested provincial government functions in November 2003, and that there had been attempts after November 2003 to implement provincialisation, even though municipality officials were contesting this policy solution. I now continue with an account of the contested implementation activities in these changing circumstances.

*Planning for transfers from municipalities to the provincial government*

To implement the decision to provincialise PPHC services, a number of transfers needed to occur. These included moveable assets such as mobile clinics, fixed assets such as clinics, and of course the transfer of staff. After March 2005 a Provincial Task Team was created to plan and drive the process of taking over PPHC services from municipalities in the non-metropolitan municipal area. The task team was comprised of provincial health officials. It also had sub-task teams that focused on aspects such as the human resources within the municipalities and finances. At this point the MEC for Health indicated that health personnel would not lose their positions. Based on the meeting minutes it would appear that the trade unions were invited to the task team meetings, but their comments suggest that they did not consider themselves part of the task team. Indeed a SAMWU representative had asked that it be noted that they were considering what their role was in this process.

In this round of planning to implement provincialisation the municipality trade unions, in particular IMATU, continued to note their dissatisfaction with the decision to transfer PPHC services. The Human Resources Sub-Task Team was responsible for addressing issues such as the nature of service conditions of the different municipalities in the non-metropolitan area.<sup>113</sup> However, the IMATU representative noted in a correction (11 May) to the meeting minutes of a Team meeting on 25 April 2005 that IMATU participation in the process was subject to the Minister's answer regarding the legitimacy of the decision to take over PHC services (Human Resources Task Team, 2005: 1). SAMWU made an additional correction to the previous meeting's minutes. Its representative indicated that they did not demand to be part of the Provincial Task

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<sup>113</sup> Human Resources Task Team meeting held at the Local Authority Bargaining Council Offices in Parow on 11 May 2005

Team, but that they wanted clarity on the terms of reference of the committees so that they could assess whether they would participate or not (Human Resources Task Team, 2005: 2). IMATU and SAMWU were clearly both still contesting the transfer process.

Minutes of the Human Resources Task Team meetings indicate that IMATU proposed an intergovernmental staff transfer based on the labour relations process that deals with a going concern. IMATU proposed a “smooth Section 197 transfer by ensuring that all collective agreements are transferred to the new employer and that employees transferred are on the whole not less favourable by comparing their total package of their conditions of service to that of the new employer” (Human Resources Task Team, 2005: 4). In response a Task Team member from the provincial health department noted that the process would follow the protocol of other processes. Employer parties would first discuss the terms of reference and then the unions would be approached (Human Resources Task Team, 2005: 4). This implied that the South African Local Government Association (SALGA) and the PGWC senior management were already discussing the details of the takeover process, which would include the nature and extent of human resource transfers.<sup>114</sup> The representative from SALGA noted that the two employers were already discussing administrative matters, but there were certain concepts about which they did not agree (Human Resources Task Team, 2005: 4).

The issue of how to undertake the personnel transfer to facilitate the provincial government takeover of PPHC services remained on the team’s agenda in the following months. The meeting minutes of the Provincial Technical Team of 19 January 2006

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<sup>114</sup> At this point WECLOGO, the Western Cape Local Government Organisation, no longer existed. SALGA became the new employer representative agency for the municipalities in the Western Cape Province. It is unclear how the representative organisation of the municipalities had changed in the Western Cape Province. However, a municipality official suggested that this change from WECLOGO to SALGA had indeed affected agreement on provincialisation.

held at the Protea Hotel in Stellenbosch noted that there are two ways to transfer staff: either in terms of section 197.2 or 197.6 of the Labour Relations Act (Provincial Technical Team, 2006: 4-5). The trade unions, particularly IMATU had argued for a transfer that meets the condition that the transferred person would move from the municipality to the PGWC with their existing service conditions. The meeting minutes indicate that a transfer in terms of section 197.2 was not considered feasible, because of the structure of the service conditions within the public service (Provincial Technical Team, 2006: 5). The Provincial Technical Team meeting minutes note another option was suggested, which was that if there is a municipality with a few health staff and if everyone agrees to the service conditions and no one is in a less favourable position, then the transfer can take place quickly. Some municipalities had shown an interest in this process (Provincial Technical Team, 2006: 5).

The transfer of health staff was presented as a problem that municipalities should work to resolve. The Human Resources Task Team chair noted to the municipal representative that municipalities could no longer provide personal primary health care services and if they retained staff they might have to retrench staff at their own expense (Provincial Technical Team, 2006: 5). Municipalities were at this stage encouraged to sign an agreement with the PGWC as soon as possible (Provincial Technical Team, 2006: 5).

Questions were also raised about the PGWC's deadlines for staff transfers and for taking over PPHC services. According to a representative from the office of the MEC for Health, the MEC did not want to disadvantage any staff and therefore wanted a negotiated settlement before 1 March 2006 (Provincial Technical Team, 2006: 5). The

Western Cape Department of Health was planning to assume operational management of PPHC services from 1 March 2006. The key concern was what it would mean for the health staff, as they would be on the municipal staff establishment and under the municipality management, while provincial health managers controlled operations (Provincial Technical Team, 2006: 6). The Provincial Technical Team chairperson noted that this was dealt with in the memorandum of agreement between the municipalities and the PGWC (Provincial Technical Team, 2005: 6).

While meetings were underway and data were gathered to facilitate implementation, more specific actions were being undertaken by municipality trade unions to challenge provincialisation. The Independent Municipal Association of Trade Unions (IMATU) initiated court action against the national and provincial government to contest provincialisation. IMATU official (2) explained:

We've actually lodged a case in the high court in Johannesburg, the case will be heard ... in the near future. The basis of our argument is ... the constitutionality of the new health act... ..it's more a service delivery argument and it's the fact that local government possess much more..., they've got these mobile clinics which go out to the people... and the whole idea when the new dispensation came to be after the post-apartheid was to bring the services to the people who need it most...

The argument centred on what IMATU believed provincialisation would mean for the goal of health system reform and in particular for service delivery. Based on this perspective, provincialisation would not take services to the people. They also pointed out that municipalities already have health service delivery strategies.

IMATU official (2) also noted that they were taking action because provincialisation was part of a national government plan that would do away with municipalities.<sup>115</sup> This comment indicates that municipality trade unions such as IMATU had understood the decision to provincialise within the context of developments at the national level of government where, they suggest that initiatives underway to create a single public service in which municipalities would not have a part.

These descriptions of an aspect of the planning for implementation process, which began after March 2005, indicate that the provincial government officials who were on these committees were proactively working to take over PPHC services from the municipalities in the non-metropolitan municipal areas. Furthermore, what is particularly evident is that the municipality trade unions were present but unwilling to facilitate the process and were instead still attempting to challenge provincialisation. An interesting aspect to note is that the municipality trade unions had interpreted provincialisation within a broader context, which would have serious implications for the size and possible survival of the trade unions operating at a municipality level.

*A municipality continues to contest provincialisation*

Other actors besides the trade unions were still contesting the legitimacy of provincialisation after March 2005. At the Provincial Technical Team meeting on the 19 January 2006, held in Stellenbosch, the chairperson indicated that the purpose of the meeting “was to inform everybody of the progress with technical issues and not about negotiations.” Even so, just under a year after the May 2005 meeting some actors were still seeking to use the task team meetings to keep issues on the table.

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<sup>115</sup>Interview with IMATU official (2) at the IMATU office.

The CWDM (Cape Winelands District Municipality) (2005a) in particular continued to contest the PGWC decision to provincialise PPHC services.<sup>116</sup> A document titled “Press Release regarding Meeting between the Executive Mayor of the Cape Winelands District Municipality and the MEC: Health in the Western Cape Province, Mr Pierre Uys held on Tuesday 17<sup>th</sup> January 2006” indicated that the CWDM and the PGWC had been in disagreement since November 2003. The CWDM Annual Report (2005b: 70; 169) for the financial year 2004 to 2005 also notes that the CWDM has had a long-standing dispute with the PGWC, which had not been resolved in 2005 at the time when the annual report was completed.

The CWDM questioned whether provincialisation was the appropriate tool for PHC service delivery, offering a number of arguments to support a transfer of PPHC services to municipalities. It argued that local government was the appropriate agent for delivering primary health care services, because there is a direct link between local government functions and personal primary health care, that international good practice supports “integrated local delivery” that the CWDM had innovative delivery programmes such as the lay worker project, which the PGWC had overlooked.<sup>117</sup> Furthermore, CWDM argued that national policy and legislation support decentralised health care delivery (CWDM, 2005b: 169).

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<sup>116</sup> The Cape Winelands District Municipality scheduled a meeting with the Premier of the Western Cape Province to discuss personal primary health care services. The response from the Premier’s office indicates that this meeting was scheduled for 26 May 2005 at the Premier’s Office in 7 Wale Street, Cape Town (Cape Winelands District Municipality: 2005a).

<sup>117</sup> Press release on the meeting between the executive Mayor of the Cape Winelands District Municipality and the MEC: Health in the Western Cape Province, Mr Pierre Uys held on 17 January 2006.

The CWDM argued that provincialisation was not justifiable on financial arguments, with the financial argument for direct delivery by the province being no longer relevant, “as the national government had provided additional funding in the 2004/2005 budget to cover any anticipated shortfall.”<sup>118</sup> The CWDM also noted in an annual report that “...since the start of provincialisation in May 2005, the costs of providing PPHC in the districts of the Western Cape had increased substantially. For one, health staff is being attracted from municipalities to province through the offering of significantly higher salaries” (2005b: 169). The lack of engagement on the provincialisation of PPHC services when funding was no longer an issue indicates that the PGWC were committed to provincialisation.

The CWDM raised additional grievances regarding actions taken to implement provincialisation. “Municipalities have been deliberately under-capacitated by province through the blocking of staff appointments on their organograms and the advertising of municipal vacant posts on the PGWC staff establishment at significantly increased salaries.”<sup>119</sup> Senior department of health official (1) contested this interpretation of what the provincial Department of Health was doing with the argument that they were filling positions that municipalities were not filling.<sup>120</sup> In the light of the grievances the CWDM noted that “The Cape Winelands has refused to sign such an agreement and argues that the decision by province was not transparent,

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<sup>118</sup> Press release on the meeting between the executive Mayor of the Cape Winelands District Municipality and the MEC: Health in the Western Cape Province, Mr Pierre Uys held on 17 January 2006.

<sup>119</sup> Press release on the meeting between the executive Mayor of the Cape Winelands District Municipality and the MEC: Health in the Western Cape Province, Mr Pierre Uys held on 17 January 2006.

<sup>120</sup> Interview with senior provincial health official (1), 72.

properly consulted and considered.”<sup>121</sup> It noted that the national Department of Provincial and Local Government had published guidelines for assignment and delegation, which allow municipalities to initiate assignment. The CWDM argued that legislation, principles and procedures need to be followed to solve this matter and the communities should be consulted on the issue, because is a significant decision as it is taking service delivery decisions further away from the people.

The question thus arises as to why, while there was documentation that could guide decentralisation of PHC services, did the PGWC or Western Cape Department of Health continue to centralise PHC services under its authority? I will address this question in the next chapters, where I offer a framework within which to understand these developments in the provincial health policy context in the Western Cape Province.

However, irrespective of continued resistance to provincialisation, the Provincial Technical Team (2006: 2) reported in January 2006 that the MEC intended to provincialise PPHC services from 1 March 2006 by completing the transfer of staff, moveable assets, fixed assets and finance, and hence assuming full operational management control (Provincial Technical Team, 2006: 2). According to the chairperson of the Provincial Technical Team, the MEC for Health in the Western Cape Province considered moveable assets as community assets (Provincial Technical Team, 2006: 4). Furthermore, the chairperson noted that the PGWC had the municipality vehicles assessed and R3 million had been allocated to replace some of the vehicles and to obtain ten new mobile units to replace the old ones (Provincial Technical Team,

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<sup>121</sup> The PGWC expected all non-metropolitan municipalities who acted as health service delivery agent for the provincial government to sign an agreement that would regulate their interim relationship until the provincialisation process was complete.

2006: 4). The meeting minutes note that the Department Public Works in the Western Cape Province would take over fixed assets. Therefore once municipalities had finalised their decision to transfer a building, the Western Cape Department of Public Works would be requested to do maintenance on the building (Provincial Technical Team, 2006: 4).

According to the Provincial Technical Team minutes (2006: 5-6) provincialisation of PPHC services would mean that from March 2006 onward the Western Cape Department of Health would be responsible for operational management. In practice service delivery would be done cooperatively between the regional directors and the district management or municipalities. Staff would be allowed to give feedback to municipal managers because they were still on the municipality establishment, but they could not follow orders that were in conflict with those from the PGWC (Provincial Technical Team, 2006: 6).

In summary, between March 2005 and April 2006 the provincialisation of PPHC services in the non-metropolitan municipal area, which had begun in November 2003, continued. The process at this time was still characterised by resistance from trade unions and from one municipality in particular, the Cape Winelands District Municipality. However, what had changed is that the MEC for Health had publicly declared the Western Cape Department of Health's intention to take over PPHC services. While after November 2003 a joint working group was established to plan for implementation, this time around a provincial government team was leading the planning process for implementing the provincialisation of PPHC services. The rhetoric of the MEC for Health as reflected in the statement on provincialising PPHC services,

and the comments from the Provincial Task Team chair, suggest that provincialisation of PPHC was not open to negotiation. Although relevant to both the non-metropolitan and metropolitan areas of the Western Cape Province, implementation was delayed in the latter area.

## **5.6 Conclusion**

This chapter has drawn attention to the adoption of provincialisation as a policy solution to a powers and functions problem because in some instances municipalities were providing provincial government functions. An important point about the adoption of provincialisation was that the idea was placed on the joint intergovernmental agenda in November 2003, when municipality politicians and PGWC Cabinet members met at a Cooperative Governance Summit.

The decision to resolve a powers and functions problem through the PGWC taking over services from municipalities was significant for this research project, because PPHC services were targeted for provincialisation. Transferring PPHC service delivery to the PGWC would mean that the health service providers and facilities would be managed by the Western Cape Department of Health through its regional management offices. The municipality employer representative body WECLOGO, the municipality officials and municipal level trade unions argued that provincialisation of PPHC services was contrary to the requirements of a DHS.

There were two distinct time periods in the implementation of provincialisation between November 2003 and April 2006. Between November 2003 and March 2005 the Department of Health (PGWC) attempted to implement provincialisation, while

some municipalities, the municipality representative body WECLOGO and the trade unions attempted to contest the decision to provincialise what the PGWC termed “uncontested” functions. PGWC officials had tried to expand their human resources for PPHC services delivery and decrease the costs of PPHC services as run by municipalities. Then from March 2005 onward the implementation of provincialisation of PPHC services went full-steam ahead, once again in the face of resistance from in particular the Cape Winelands District Municipality and the trade unions operating at the local government level. Here, however, the PGWC officials took the lead in planning for provincialisation of PPHC services and it was made clear that provincialisation was not under review.

Implementing provincialisation of PPHC services was characterised by attempts to circumvent negotiations or other difficulties that would complicate an intergovernmental transfer process. These may have been associated with costs of engaging, for example, in a labour relations process for staff transfers. The manner in which implementation was pursued after November 2003 may have negatively affected the relationship between the Western Cape Department of Health and municipalities in the non-metropolitan area. In the case of the CWDM it is certain that the relationship would have been strained if the actors who were involved had remained in their respective positions in the two authorities.

Chapter 6 is the first chapter that offers a lens through which the key findings in Chapters 4 and 5 may be understood. The technical, intergovernmental and inter-organisational issues I have described and which various actors highlighted as important partly explain why the decision to transfer PHC to the City of Cape Town

was not implemented. In the next chapter I argue that another reason that the transfer of primary health care services did not take place was that the definition of municipal health services had led to a change of plan regarding how health system reform should proceed. I argue that the centralisation of primary health care services replaced decentralisation as the tool for building a DHS. Provincialisation was the tool and when applied, it would facilitate the implementation of Healthcare 2010 and it would create a different model of DHS than the national government anticipated.

## **Chapter 6: Shifting from intentions indicate policy change**

### **6.1 Introduction**

In this chapter I explore in greater depth the meaning of a key research finding, which is that the PGWC changed its expressed policy intention regarding the transfer of PHC services from decentralisation to centralisation. In Chapter 4 I showed that in 2001 the PGWC had expressed the intention to decentralise PHC services, when they decided to initially transfer these services to the City of Cape Town municipality. However, as Chapter 5 shows, by November 2003 there was a decision to provincialise PPHC services. This decision reversed the direction of the transfer. The shift to provincialisation is significant, because it has implications for the type of DHS that would be created in the Western Cape Province. Decentralising PHC services to the health district level would have led to a municipality-run DHS. However, the decision to provincialise PPHC services centralises these services – a higher level of government, the provincial government, becomes responsible for PHC services and thus creates a province-run DHS. Based on the existing provincial health management structure in place during the research period, this would have meant that the provincial health management would not be in line with the nationally defined health district boundaries.

In this chapter I start to apply the persuasion framework discussed in Chapter 2. I first discuss why the shift from the intention to decentralise to a decision that leads to centralisation of PPHC services should be interpreted as an instance of policy change. To demonstrate this I contrast the national policy expectations with what provincialisation of PPHC services produces in practice, particularly its implications

for health services integration and DHS governance in the Western Cape Province.

Second, I demonstrate that the conditions and motivations for policy change, which I outlined in the theoretical framework, prevailed in this context. The condition that would facilitate policy change was that there was sufficient decentralisation in the government system to allow lower levels of government to take decisions which are more than the implementation of policy decisions taken at higher levels. I will discuss the formal powers of provincial governments and their powers in relation to local government.

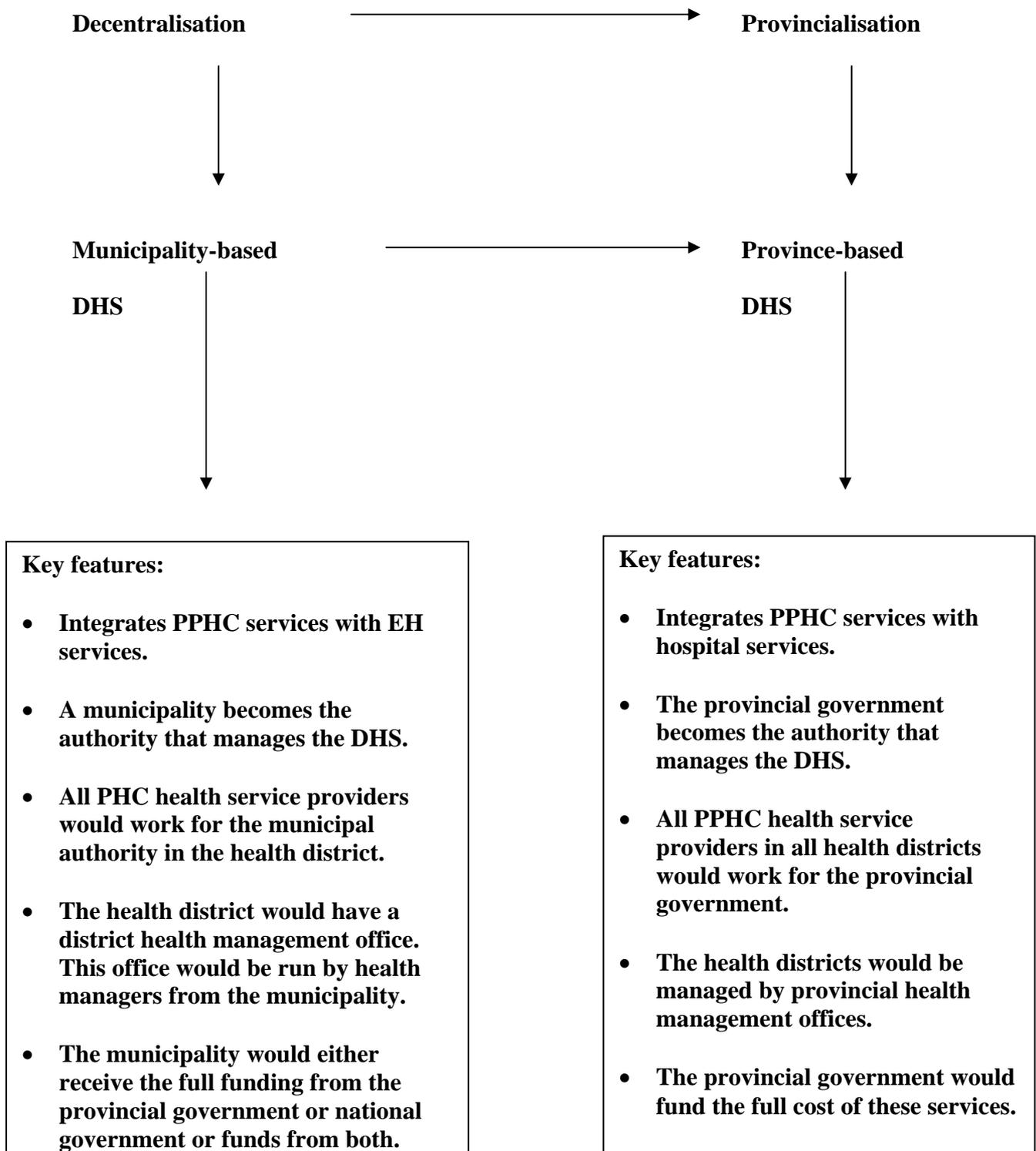
I will also explore the motivation for policy change, arguing that preventing “continual painful losses” (Welch, 2005: 8) and “maintaining institutionalised ideas” (Goldstein and Keohane, 1993: 3) were significant factors in this context. The PGWC Cabinet and the MEC for Health were the key decision makers in the provincial health policy context and thus I examine the conditions and motivations related to these actors. This chapter concludes with a summary of the main points made to explain why this shift in policy position on health system reform should be understood as an instance of policy change.

## **6.2 The mismatch between national policy expectations and what provincialisation produces**

The discussions in this section focus on two key themes: health service integration and DHS governance. I demonstrate that the provincialisation of PPHC produces effects that realise an alternative policy picture to the one that the national policy expectations would lead one to expect. This alternative policy picture, created by a provincial

government policy decision and secured through implementation activities, constitutes policy change.

The following diagram expresses why the shift from decentralisation to provincialisation constitutes policy change.



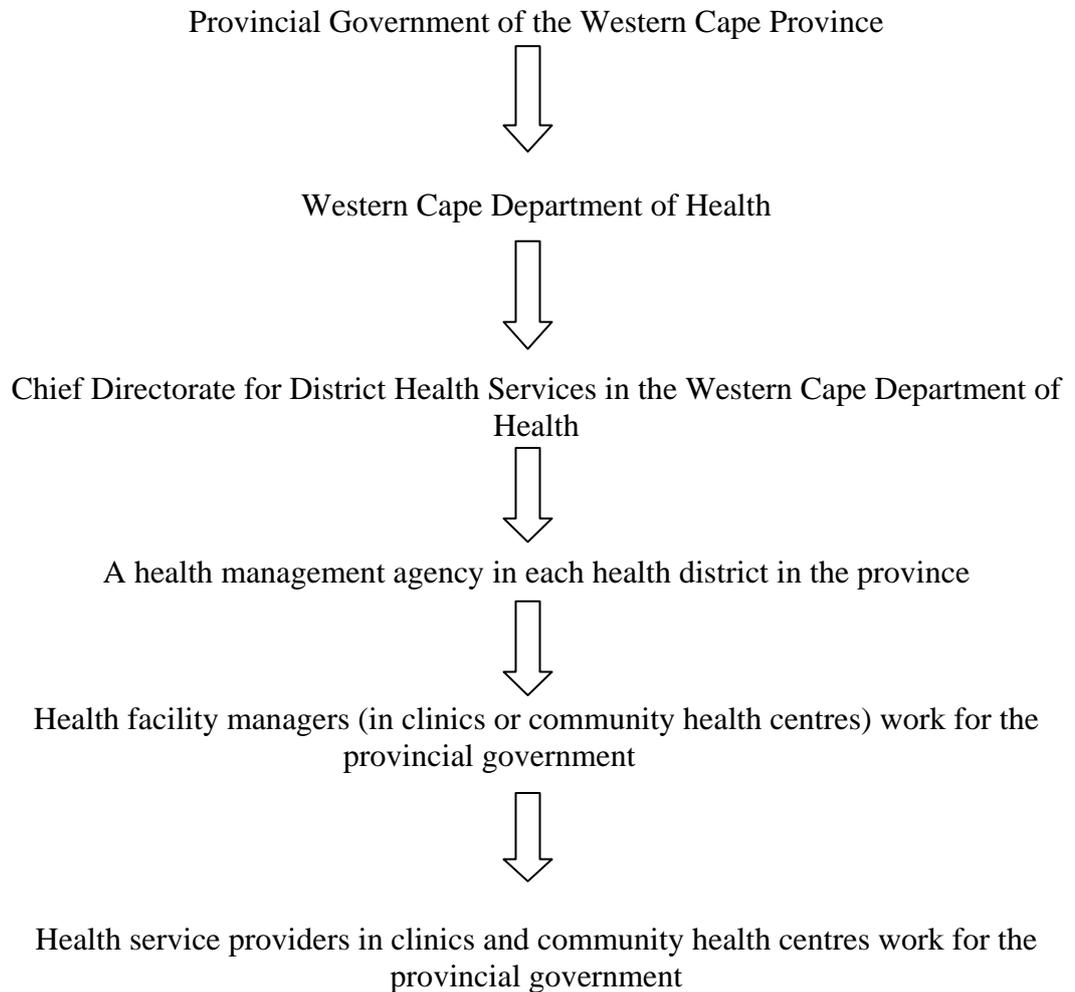
This diagram demonstrates the implications of decentralisation and provincialisation respectively. It highlights the point that if decentralisation had occurred, then a municipality-based DHS would have been developed. It also demonstrates the implications of provincialisation, which is that it creates a province-based DHS.

The shift in terms of the nature of health governance is demonstrated below. The thick arrows indicate that the organisation or individual above the arrow has authority over the organisation or individual below the arrow.

**Model of decentralised health governance: a municipality run DHS**



**Model of centralised health governance: a province run DHS**



*National policy expectations regarding health service integration and DHS governance*

The overarching framework that informed health system reform in a post-apartheid South Africa is the WHO's PHC approach and the DHS, a decentralised form of health management that facilitates linking health management planning with the particular needs of a health district. The PHC approach promotes integrating primary health care services at a health district level. The earliest National Department of Health document on a DHS in South Africa notes that comprehensive primary health care services should be provided in a health district and these services include "all essential care, including

environmental health services, emergency services and first-level hospital care” (Owen, 1995: 7). Because the national policy goal is to have a single authority responsible for the DHS (Pillay *et al.*, 2003: 3), this means that the aforementioned health services, which comprise comprehensive PHC services, need to be managed by one authority.

One of the most significant policy expectations for establishing a DHS was decentralisation. It is referred to in a number of significant national health policy documents. The National Department of Health’s discussion document on developing a DHS for South Africa issued in 1995 noted that decentralisation meant that the DHS should be under the authority of the local government (Owen, 1995). The White Paper on the transformation of the health system (1997) states the following in its preface: “We intend to decentralise management of health services, with emphasis on the district health system - increase access to services by making primary health care available to all our citizens.” Furthermore, the White Paper (1997) describes the role of provincial governments as being to create a provincial District Health System based on the PHC principles. This suggests that the interim arrangement was that provincial governments would provide some services until these services could be devolved to health districts. Provincial governments were thus responsible for interim service delivery, while the DHS was being developed. Furthermore, this suggests that the PHC services would be transferred to the local government authority, which means that it would be transferred to municipalities. In 2001 the MinMEC promoted a municipality-based district health system and comprehensive primary health care would be delivered at this level (Barron and Asia, 2001: 17). We can therefore say that a national health policy maker and the nine provincial governments that act as implementing agents had agreed in 2001 that municipalities should manage PHC services.

While decentralisation was the preferred national health policy goal for health system reform, the details of this decentralisation were still unclear. Decentralising primary health care services could mean different activities with varying implications. For example, decentralisation could mean transferring the PHC services function to local government, meaning to all municipalities. One would expect that because the national and provincial governments are jointly responsible for health services, which includes all PHC services besides EHS services, both spheres of government would have to agree to the transfer.

Decentralisation of PHC services could also mean that the provincial or national government transfers these services through agency agreements. Section 156 (4) of the South African Constitution (Republic of South Africa, 1996: 84) and Section 32 of the National Health Act (Republic of South Africa, 2004: 42) make provision for such a transfer. In fact, Section 32 of the National Health Act refers back to the provisions in the South African Constitution for matters related to developing a service-level agreement. This suggests that the national policy intention was for decentralisation of service delivery and management, and not for a transfer of the function. This interpretation of the national policy intention seems accurate, if one considers the comment by senior provincial health official (1) about the meaning of the National Treasury's additional funding allocation for the PPHC services that municipalities provide:

So Trevor [Manuel, Minister of Finance] announced in 2004 that the Treasury has made provision for 300 million rand escalating over a three-year period to the provinces. Now we interpret that he supports for us to provincialise the service. Other provinces said that was not what he said. We don't agree with

them; they say they are giving the money to you, so you can give it to local government.

Senior provincial health official (1) notes that they interpreted the funding allocation from the national Minister of Finance, Trevor Manuel, as an incentive to continue provincialisation. The significant point here is that the other provinces seem to have argued that the intention was that the PGWC should transfer that money to municipalities and thus continue decentralised primary health service delivery through agency agreements with municipalities. Decentralisation in the health policy context therefore meant delegating service delivery and management to a lower-level authority.

*Implications of provincialisation of PPHC services for health service integration*

In the Western Cape Province the municipalities were providing PPHC services, EMS services and EHS services. The municipalities were providing PPHC services on behalf of the provincial government because the 1977 Health Act and the South African Constitution (Republic of South Africa, 1996) were the legal bases from which the Western Cape Department of Health determined its health responsibilities. Municipalities were providing EMS on behalf of the provincial government, but according to the South African Constitution, this was a provincial government function (Republic of South Africa, 1996: 146).

The Western Cape Department of Health annual report indicates that by 2003 only the metropolitan municipality EMS staffs were still to be provincialised (2003: 17). The provincialisation of EMS meant that the service delivery aspects, the ambulance vehicles and staff, were to be transferred from the municipalities to the authority of the Western Cape Department of Health. These EMS services were being identified as part

of the comprehensive primary health care package in the Department of Health's policy document on DHS implementation (Owen, 1995: 7). The provincialisation of EMS may thus be viewed as a first step toward integrating PHC services in the Western Cape Province under one authority. The authority under which integration occurred in the case of EMS is the authority responsible for the function, which is the provincial government.

When the National Health Act (Republic of South Africa, 2004) came into effect in 2005, the Western Cape Department of Health then referred to this legislation when explaining its health function. The Act defines municipal health services as environmental health services (Republic of South Africa, 2004: 14). The implication of this definition of MHS was that the national government and the nine provincial governments were now responsible for all other health services except water and sanitation services. PGWC's decision to provincialise PPHC services was based on the argument that the personal primary health care services that municipalities were providing were now legally their responsibility. The 2004 National Health Act had replaced the 1977 Health Act, which the provincial Department of Health refers to under District Health Services in its annual report. Thus health service integration was once again subject to the issue of who was the designated responsible authority. In other words, health service integration was not based on the national policy vision of comprehensive PHC services being managed by one authority in a health district. Instead health services integration was driven by what the PGWC understood as its legal health responsibility.

*Implications of the provincialisation of PPHC services for establishing a DHS*

Provincialising PPHC services implies that the PGWC policy position regarding significant aspects related to health system reform had changed between 1997 and 2003. In particular, the PGWC policy intentions shifted from decentralisation, which was the PGWC Cabinet policy intention in October 2001, and which was then in line with the national policy expectations. The main reason why this represents a deviation from earlier stated national and provincial policy positions is that the provincialisation of PPHC services would, in effect, centralise PPHC services under the Western Cape Department of Health's authority.

The Western Cape Department of Health's regional health management offices represent a form of internal decentralisation of health management. However, this form of decentralisation, otherwise known as deconcentration, does not comply with the national policy expectations for a DHS. A DHS means that each health district has a health management office in the health districts. According to the National Health Act (Republic of South Africa, 2004), the health districts in South Africa comprise the areas of jurisdiction of metropolitan and district municipalities. Therefore in the metropolitan municipal area where MDHS is the regional health management office, provincial health management offices and the health district boundaries overlap. However, in the non-metropolitan municipal area regional health management offices now often manage health services for two district municipalities. For example, the Western Cape Department of Health manages its health services in the Cape Winelands municipality and the West Coast municipality area through a regional health management office, West Coast/Winelands. Cape Winelands is a district municipality and thus the health management should not overlap with boundaries of this district municipality.

The Department of Health (PGWC) noted in 2006 that it was aiming to reform its regional health management structure. According to the Western Cape Health Department Summary Draft Comprehensive Service Plan (2006: 6), the regional management structures, West Coast/Winelands, Boland/Overberg and Southern Cape/Karoo will become district management structures. The provincialisation of PPHC services thus appears to be a precursor for creating a DHS where the PGWC would reform its health management structures so that they are congruent with health district boundaries. These regional management agencies would then become responsible for all the facility-based health services provided within each of the health districts.

Even though provincial governments and the municipalities are sub-national layers of government in the South African government system, provincialisation should be interpreted as an act that leads to centralisation. First, provincialising PPHC services means transferring the responsibility for managing and delivering these health services to the provincial government, a sphere of government that is further away from the people. The national policy vision, however, was that PHC services should be transferred downward to municipalities. Municipalities constitute the local sphere of government in South Africa and they are often the closest authority to the people in terms of the geographical location of the administration. The provincialisation of PPHC can thus be understood as a way of centralising decision-making authority, because it transfers the management responsibility for services that should be planned and managed in a health district upward, to a higher sphere of government. Second, provincialising PPHC services may be understood as centralisation, because PHC

service delivery and management were not being transferred downward from the responsible authorities, which are national and provincial governments.

Implementing provincialisation of PPHC services to a certain extent establishes a single authority over the health districts in the Western Cape Province. The decision about which authority should be responsible for the DHS has been long in the making. In Chapter One of the Health Systems Trust ten-year review of health system reform in South Africa, the authors Ntuli and Day (2004: 3) note that “Over the years, commentators in the Review have regretted absence of national legislation to guide the developments in the sector and clarify the responsibilities of all three spheres of government.” This research project indicates that instead of national policy makers resolving the matter of governance over the DHS, the PGWC established itself as the single authority over the DHS in the Western Cape Province based on how national government had defined municipal health services.

Whether the PGWC is in fact the authority over the DHS is subject to which definition of comprehensive PHC is used. If one thinks of comprehensive PHC services as those services that are meant to be integrated into a health district, then the Western Cape Department of Health is managing a part of the comprehensive PHC package, because municipalities are legally responsible for EHS, which is a component of PHC services. However, the National Department of Health’s definition in their guideline on the Comprehensive PHC Package (Peterson, 2001) suggests that the provincial health department is in fact responsible for all health services that should be provided in a health district. The National Department of Health defined comprehensive primary health care services as all primary health care services provided in health facilities at

the district level and it excludes level-one hospitals (Peterson, 2001: 11). The reference to health facilities excludes EHS as a part of comprehensive PHC package.

Another important point to note is the difference in emphasis between the national government and provincial government regarding the vision for the health system. The goal of the national health policy vision is to expand South African's access to a range of basic, publicly provided health services through integrated primary health services within the health districts. On the other hand, if the Department of Health (PGWC) proceeds to implement provincialisation, health system reform will comprise integrating primary health care services, which are provided at community health centres and clinics, with secondary and tertiary level health services, which are provided at hospitals. The goal which provincialisation achieves is an integrated health system where the referral process for clients between different levels of care is simplified. This is not to suggest that the Department of Health (PGWC) does not also seek to broaden access as well. In the following discussion we will see how broadening access fits in with creating an improved referral system between the health care facilities for the Western Cape Department of Health.

In summary, based on national health policy expectations, the DHS in the Western Cape Province should have been one where the municipalities, specifically metropolitan and district municipalities, deliver and manage comprehensive PHC services in the six health districts. However, provincialisation of PPHC leads to centralised PHC service delivery and management, and it establishes the PGWC as the authority over the DHS in the Western Cape Province. Furthermore, provincialisation appears to have set the groundwork for internal reform within the Western Cape

Department of Health, which would then align provincial regional health management agencies with health district boundaries. This is not the municipality-based DHS that national policy documents suggest should be the case, but rather a province-based DHS. This indicates that a policy change has occurred. In other words, the PGWC Cabinet created a different type of DHS and this happened before national health policy makers adjusted their perspective on health system reform toward supporting provincialisation.<sup>122</sup>

### **6.3 Provincial governments have significant discretion**

One of the major facilitating factors in the persuasion framework is discretion. Provincial governments in South Africa have the scope to take decisions about how they will implement national health policy. Therefore provincial governments are able to take decisions that can lead to policy change. I discuss the nature of decentralisation in the government system to demonstrate the extent of provincial governments' decision making capacity.

#### *Decision-making scope in the South African government system*

Perhaps the most important ability that empowers the provincial government would be the ability to raise revenues and to decide how to spend such funds. While provincial governments in South Africa are limited in terms raising revenue, the national government has given provincial governments the power to decide how they spend the funding allocations that they receive from the national government.

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<sup>122</sup> The national health authority later on supported provincialisation in all provinces in South Africa. But this was viewed as a short-term strategy until municipalities were capable of taking over the services.

This type of fiscal decentralisation is referred to as fiscal federalism. According to McIntyre and Klugman (2003: 110, 113), fiscal decentralisation means that the national government transferred decision making regarding budgetary allocations to the provincial treasuries and provincial legislatures as well as municipality treasuries and municipal councils. This ability that the provincial governments have acquired allows them to decide how and whether they implement national policy.

Apart from empowering the provincial governments, fiscal federalism has also created powerful provincial and municipal treasuries that can allocate resources to the different policy sectors. McIntyre and Klugman (2003: 113), who conducted research on the effects of decentralisation in health service delivery, noted that health managers whom they interviewed had indicated that implementation suffered because budgets were not adjusted in accordance with policy changes. Senior provincial health official (1) also noted that the power of the Provincial Treasury had affected the possibility of implementing the transfer decision: “The first and foremost thing is the Provincial Treasury said to us that they will not, they have to sign the root form. They will not sign the delegation to local government. They will only sign what they call an assignment, which is what the Constitution prescribes.”<sup>123</sup> Thus provincial treasuries can facilitate or hamper policy implementation.

The scope of provincial government decision making must also be examined in relation to the nature of the government system. The South African government system is best described as a hybrid system and for this reason it is important to pay more attention to provincial government decisions. Introductory political science texts, such as

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<sup>123</sup> Interview with senior provincial health official (1), 72.

Heywood's *Politics*, note that federal states are characterised by two relatively autonomous levels of government, whose existence is based on a constitution and not on the whims of a central government (Heywood 2007: 169). In South Africa the Constitution refers to three spheres of government and these spheres have different functions. Furthermore, the provincial governments are meant to represent regional interests and thus provincial governments have representation in the national parliament through the National Council of Provinces.

However, the South African Constitution (Republic of South Africa, 1996) also indicates that the South African government system has features of a unitary system. Heywood (2007: 171) notes that in unitary systems power lies with the central government and peripheral governments exist because national government allows them to exist. The unitary element in the South African government system is that national government authority is always above provincial government and municipality authority. Thus there is no power sharing as one expects to have in a federal system.

Provincial governments in South Africa have more power than they use. Van Zyl (2003) argues that the provincial governments are not as strong as they should be in terms of constitutional provisions. For example, the national government and the provincial governments are both responsible for health services. This implies that both spheres of government are able to make health policy. However, negotiations between the national government and provincial governments led to an agreement where national government sets the guidelines and provinces implement policy within these guidelines (Pillay, 2001).

One reason why provincial governments in general do not use their constitutionally assigned powers to more effect is that the African National Congress is dominant in the government system in South Africa. The ANC has retained control over the national government since 1994. It has also won at least seven out of the nine provincial governments in the provincial elections since 1994. When the ANC wins a provincial election, it selects the main provincial government actor, namely the premier. This action is meant to secure the allegiance of the provincial government to the national governing party agenda and to ensure that it implements the national government's mandate.

An important question thus is whether provincial governments who are run by opposition parties have also toed the national government line. When looking back into the political history of the Western Cape Province, it becomes evident that the opposition parties who have run the provincial government have challenged the national government. After the 1994 elections the NNP was the government in the Western Cape Province and it challenged the national government, when it believed that it was attempting to encroach upon provincial government powers.<sup>124</sup>

However, it is interesting in this case that the opposition-led governments took decisions that were in line with national health policy, while an ANC-led provincial government took the decision to provincialise personal primary health care services.

For example, the coalition government of the New National Party (NNP) and the

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<sup>124</sup> The NNP resisted what it perceived as an attempt by the ANC to encroach on provincial government. This centre-periphery tension was not only the product of rivalry between two parties who had been at loggerheads since 1948, but it was also a tension emanating from the transition negotiations. As part of the transition pact the ANC had agreed to the request from the National Party and the Inkhata Freedom Party for provincial governments. These parties wanted a federal government structure as this would allow them a chance to be involved in government in the provinces that they expected to control after the elections.

Democratic Party (DP) took the 2001 decision in principle to transfer primary health care services to the City of Cape Town municipality. The Democratic Alliance was also governing the City of Cape Town municipality at the time. This decision could have been part of a power-sharing agreement between the NNP and the DA, who jointly governed the Western Cape Province. The provincial ANC government in the Western Cape Province was thus acting assertively, because it took a decision to provincialise personal primary health care services, which works against developing a decentralised DHS.

The ANC provincial government in the Western Cape Province had developed a vision for economic development and provincialisation was one of the tools to implement vision.<sup>125</sup> Provincialisation was therefore not only applicable to the public health sector in the Western Cape Province. It was also applicable to other PGWC functions such as library and museum services. The Cooperative Governance Summit document (2003) explained that provincialisation was important, because developing the province requires that each sphere of government in the province should take responsibility for its own services. Provincialisation was one of the instruments that the PGWC was using to implement *Ikapa Elihlumayo* (The Growing Cape), the PGWC's development policy vision.

#### *Decision-making scope in the public health policy sector*

The South African Constitution (Republic of South Africa, 1996) provides provincial governments with legal policy-making powers in the public health sector, because health services are a concurrent function of national and provincial governments. This

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<sup>125</sup> *Ikapa Elihlumayo* was enacted in 2008. Its status as a significant policy framework that will shape provincial policy generally was thus established in law, even though it seems to have been shaping government policy decisions from 2003 onward.

means that provincial cabinets and legislatures are legally able to take policy decisions on health matters pertaining to the Western Cape Province. Harrison (in Forman *et al.*, 2003: 17) noted the implications of national and provincial government both being responsible for health services. The implication was that ten policies could be developed on healthcare if there was no coordination between national and provincial governments (Harrison in Forman *et al.*, 2003: 17). The key problem here was which authority would be responsible for which respective policy functions such as policy-making and implementation.

The issue regarding which authority would play what policy role was clarified through negotiations between the national and the provincial governments. Provincial governments came out of the negotiations as implementers and national health policy officials as the policy makers who would set the policy framework for implementation (Pillay, 2001: 757). The White paper on the transformation of the health system (1997) ascribed the role of DHS development to provincial governments. Provincial governments, meaning provincial politicians, health management and those at the front line of service delivery, such as nurses, were responsible for transforming the health system in the Western Cape Province. This is a different conceptualisation of those who implement policy as the frontline service delivery agents such as nurses are often the focus of research.

The discussion on decision making scope is an exploration of the extent to which implementers have discretion to take health policy related decisions. In the previous chapters we saw that health policy implementers, namely the provincial and municipal health managers for the metropolitan municipal area, implemented different strategies

to integrate primary health care service delivery at the health facility level. The guidelines for functional integration did not prescribe how functional integration should occur. Thus the managers closest to the frontline of health service provision attempted three different strategies to integrate primary health services in health facilities. According to a Senior National Health official (2), this decision-making scope is legitimate. Indeed, when asked about provincialisation this official noted that the issue of provincialisation is misconstrued, because provinces can do what they want to do as long as long as they are acting within national guidelines and get the desired outcome.<sup>126</sup>

In summary, the South African Constitution provides the legal space for provincial governments to take policy decisions regarding the provision of health services. The national government's devolvement of power on spending their budgets provides provincial governments and municipalities with the space to decide what policy initiatives that stem from the national government they would fund. Their freedom in terms of deciding on their spending is subject to regulations, which mainly centre on ensuring financial accountability. The important point is that provincial governments have extensive space for discretion to decide on strategies for health system reform and policy implementation generally. This means that the PGWC was acting more assertively when it adopted provincialisation.

#### **6.4 Motivations for adopting provincialisation**

An important notion in the persuasion framework is that there were motivations that led to the initiation of policy change. Below I examine the material in terms of two

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<sup>126</sup> Telephone interview with senior national health official (2) on 8 March 2006.

motivations for policy change discussed in Chapter 2. In terms of the persuasion framework the motivations for policy change would be avoiding “continual painful losses” (Welch, 2005: 8) and “maintaining institutionalised ideas” (Goldstein and Keohane, 1993: 3). The following key themes represent these motivations either individually or collectively: policy change maintains the status quo in terms of who has the power in the public health system; it maintains the institutionalised idea that health service integration means integrating district health services instead of primary health care services; and it creates a foundation for a vertically integrated health system.

HealthCare 2010 facilitates the creation of a vertically integrated health system in the Western Cape Province. The interesting point about policy change in this context is that change was adopted to conserve or preserve established interests. Hinnfors (1999: 295) pointed out that policy actors might take policy decisions that initiate policy change, but the aim of policy change is to maintain the status quo in terms of ideological stability.

*Maintains the power status quo*

The provincialisation of PPHC services will ensure that the PGWC remains the key authority within the provincial public health sector in the Western Cape Province, because the provincial government becomes responsible for primary health care services and hospital services. These two sets of services represent the majority of the public services, the other set being environmental health services.

When provincialisation of PPHC services is implemented, it will give effect to health service integration, but in a way that places facility-based PHC services and hospital

services under the PGWC's authority. The provincialisation of PPHC services represents a change in the approach to health services integration. Instead of decentralising its PPHC services to municipalities in the province, it takes over PPHC services and thus ensures that the provincial government remains the main authority delivering public health services in the Western Cape Province. The provincialisation of PPHC services through its effects on health service integration thus reinforces the status quo.

Reforming the health system by creating a DHS based on the primary health care approach threatened to shift funding allocations from the situation prior to 1994. During the apartheid era the health system was orientated toward curative health services. These services were provided in hospitals and day hospitals (now called Community Health Centres). The provincial governments were responsible for these curative health services in these facilities and were the main recipients of national government funding designated for these health services. Taking over PPHC services from the municipalities in the Western Cape Province also means that the PGWC government would once again be the main recipient of any funding which the national government allocates to PPHC services.

In the post-apartheid dispensation the focus of the health system shifted to PHC services. A health system that focused on PHC services would require an integration of the curative health services that the provincial government provides along with health promotion and prevention services as well as the environmental health services which municipalities provided. Furthermore, the national policy makers emphasised a DHS, meaning a decentralised health management and they promoted the establishment of a

municipality-based DHS. These national policy expectations for health system reform would lead to municipalities becoming the key authority in the public health system. If municipalities were to be given the leading role in public health service delivery in South Africa, they would need to receive funding from the national and/or provincial governments. Whether funding to municipalities would come from national or from provincial governments would depend on the type of decentralisation that occurred. The main point, though, is that based on the expected health system reforms, the PGWC would lose financially in both the long and short term.

To understand the financial significance of provincialisation as a financial loss-avoidance strategy, we have to contrast the financial effects of decentralisation of PHC services with the provincialisation of PPHC services. Decentralising PHC services by giving responsibility for these services to municipalities would have meant that the Department of Health (PGWC) would have been transferring a substantial part of its health budget to municipalities. The reason for this is that the PGWC intention to decentralise was interpreted as meaning delegation. Delegation means transferring authority to an agency over which central government still exercises control (Galvin and Habib, 2003: 868). Senior provincial health official (1) described the implications of delegation in the following way:

The City of Cape Town that time we worked out because we had done the audit that apart from transferring those 2 000 staff members, their accrued leave and their other benefits came to R54 million. So if we wanted to delegate this function we had to look for R54 million just to pay their accrued leave benefits... that is apart from the salaries we now have to stay on parity with 1.5 differential.<sup>127</sup>

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<sup>127</sup> Interview with senior provincial health official (1), 72.

Senior provincial health official (1) was referring to the situation of delegation in the metropolitan municipal area only. We can see the significance of the costs that would be incurred if delegation of primary health care services to the City of Cape Town had proceeded. Senior provincial health official (2), who was also involved in the planning process for the initial decision to transfer primary health care services, indicated that significant amounts of money would be involved in a transfer to the City of Cape Town municipality: “Now, in the city their contribution, they [contribute] anywhere between 110 to 140 million, we give 99 or 100 million, they say they contribute 110 million – 140 million”.<sup>128</sup>

If the PGWC were going to decentralise primary health care services to the City of Cape Town, then it would have had to pay its contribution and the municipality’s contribution, because the National Health Act (Republic of South Africa, 2004: 42) only obligates a municipality to maintain its contribution until the Service-Level Agreement has been finalised. In other words, municipalities could withdraw their funding contribution to PPHC services once the provincial government and municipalities have reached an agreement on the terms and conditions of their agency contract. Decentralisation thus meant that the provincial government exercises its right to transfer the service delivery and management duties to the municipalities in the province. However, because the National Health Act (Republic of South Africa, 2004: 14) indicates, albeit indirectly, that the PGWC was legally responsible for all services except environmental health services, the provincial government would have had to fund the function that it transfers to a municipality.

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<sup>128</sup> Interview with senior provincial health official (2), 77.

The PGWC Cabinet was aware of the cost implications of taking over primary health care services from the municipalities. When provincialisation of PPHC services was mentioned in the Cooperative Governance Summit document, one of the aspects that municipalities needed to agree to was that they would decrease the costs of the health services that they provided so that the PGWC could afford to take over these services. This part of the agreement meant that, in effect, the municipalities had to cut health services provision until the PGWC could afford to fund these services on its own. The provincialisation of PPHC services under these conditions meant that the PGWC would become the primary funding agency for facility-based PHC services. Thus the additional funding which the National Treasury made available in 2004 would be allocated to the responsible agency, which is the PGWC, and they did not need to transfer these funds to a contracted authority.

In summary, provincialisation of PPHC services ensures that the PGWC becomes the single authority responsible for the majority of the primary health care services; this authority also becomes the main health service provider in the Western Cape Province and the main recipient of additional funding from the national government. Thus provincialisation keeps the PGWC in the position of power within the public health sector in the Western Cape Province and municipalities remain in a secondary position when it comes to health service delivery when the PGWC takes over PPHC services.

*Provincialisation maintains the institutionalised idea that district health services should be integrated*

The provincialisation of PPHC services may also be a purposive act aimed at maintaining established ideas within the Western Cape Department of Health. The following discussion demonstrates that district health services is a prominent theme within the Western Cape Department of Health.

Integrating district health services and integrating PHC services represent two different types of health services that would be integrated within a health district. The National Department of Health refers to both types of health services in the plan for establishing a DHS (Owen, 1995) and PHC services in the comprehensive PHC package (Peterson, 2001). Policy documents such as the Reconstruction and Development Programme (RDP) associate a primary health care approach in South Africa with “integrative care of preventative, promotive, curative and rehabilitation services.” (African National Congress, 1994). In “A policy for the development of a District Health System in South Africa” (Owen, 1995: 7), level-one hospitals (District Hospitals) are identified as facilities where health services in a health district would be provided. Then in 2001 the National Department of Health’s policy document “A Comprehensive Primary Health Care Service Package for South Africa” identified primary health services as those provided in health facilities at the district level, which excluded level-one hospitals (Peterson, 2001: 11).

These different types of health service integration represent contending ideas about the set of health services that should be rendered in a health district. The key aspects that differ in terms of the various national policy documents are whether environmental health services and first-level referral hospitals are included as services that are meant to be provided within health districts. If the health services provided in the health

districts were PHC services, then that would include PPHC services, EMS services and EHS services. If the health services to be provided in the health district are district health services, then it means PPHC services are integrated with the secondary level of care, which is provided in hospitals. Provincialisation creates the latter situation.

We can examine what health services are considered important within the Western Cape Department of Health by analysing two aspects. The first aspect is the organisational structure of the department. Goldstein and Keohane (1993: 3) noted that ideas are influential in policy when they institutionalised, meaning they are built into an organisation. Creating an organisation around an idea secures the perpetuation of the ideas, because the agency and those who work for the agency and depend on its existence will take action to maintain the idea. The Western Cape Department of Health has a section called Secondary and Tertiary Health Services, and the District Health Services Directorate falls under this section. This directorate oversees the four regional health management offices that manage district health services throughout the Western Cape Province. We therefore have within the Western Cape Department of Health a directorate that is responsible for district health services.

What do district health services mean to the Western Cape Department of Health? District health services, under Programme 2, are noted as one of six programmes conducted under the auspices of the Western Cape Department of Health (2003: 8). Programme 2 aims “To render primary health care services (Act 63 of 1977)” (Western Cape Department of Health, 2003: 8; 2004: 13). The components of primary health care services are: district management and support services, community health services, emergency medical services and district hospital services (Western Cape Department of

Health, 2003: 8). The sub-programmes listed under Programme 2 are: district management, community health clinics, community health centres, other community health services and environmental health services as well as district hospitals (Western Cape Department of Health, 2003: 18). The Western Cape Department of Health's annual report for the financial year 2004 to 2005 (2005a: 19) notes that the department is responsible for primary health care services and district hospital services. District health services in the Western Cape Department of Health thus refer to the combination of PHC services and district hospital services.

The provincialisation of PPHC services gives the Western Cape Department of Health control over primary health care services. The Western Cape Department of Health has consistently identified primary health care services as its function based on the Health Act of 1977. The provincial health department was always also responsible for a range of hospital services, which it defined as district as well as secondary and tertiary hospitals services. These services are Programme 3 in the provincial health department. By provincialising PPHC services, the Western Cape Department of Health takes total control of what it refers to as district health services.

In summary, implementing provincialisation of PPHC services would result in integrating district health services, the option from the 1995 policy document on DHS, and not comprehensive primary health care services as defined in the National Department of Health's 2001 policy document. The provincialisation of PPHC services gives the Western Cape Department of Health control over the services that it believes should be integrated within health districts, which are district health services. District health services refer to PHC services and district hospitals. The latter has been a long-

standing perspective within the Western Cape Department of Health and we see it in the organisational structure and the most recent activities for reforming the provincial public health system.

*Provincialisation facilitates the implementation of a vertically integrated health system*

Another important idea within the Western Cape Department of Health relates to how the different levels of health services should be interlinked. Senior provincial health official (1) described the PGWC Department of Health's main ideas about how the health services should be linked:

So we said that there are ... what we call non-negotiables. First is that a single authority should be accountable and responsible for district health services. One authority, this is non-negotiable. The second one is that all the staff and whoever operates in there must be employed by the same authority. [Also], that when people access health services they must be seamless and they must not be fragmented.<sup>129</sup>

The Western Cape Department of Health wants to link the different health care facilities in a way that is seamless. In practical terms the Western Cape Department of Health envisions that if a patient reports at a primary health care facility in the health district with a condition that requires hospital treatment, the patient would receive a referral directly to the level-one hospital in that health district. Furthermore, if the condition required specialist treatment, the level-one hospital would then refer the patient onward to a secondary-level hospital.

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<sup>129</sup>Interview with senior provincial health official (1), 72.

The 2004 Western Cape Department of Health annual report and the Healthcare 2010 policy document highlight that seamless health service delivery is an important idea within the Western Cape Health Department. The Western Cape Department of Health noted in its annual report that the PGWC had decided to “provincialise primary health care services” and that this “will result eventually in seamless health provision from clinic to hospital” (Western Cape Department of Health, 2004a: 2). Healthcare 2010 presents the Western Cape Department of Health’s vision for a vertically integrated health system in the Western Cape Province. This vertically integrated health system is one where primary health care services in health facilities are integrated with district, secondary and tertiary level health services. Healthcare 2010 is the basis for creating a health system where lower-level health facilities are linked to higher-level facilities that offer specialised care.

The key HealthCare 2010 goal for reorganising the provincial health system is to have a health system where 90 percent of consultations with public health clients occur at primary health care level, 8 percent at district hospital level and 2 percent of services are provided by tertiary hospitals (Western Cape Department of Health, 2003a: 18). Provincialising PPHC services gives the Western Cape Department of Health the ability to implement its Healthcare 2010 plan. The implementation of provincialisation creates the foundation for implementing HealthCare 2010 by drawing PPHC services into the provincial government health structures and thus the PGWC is responsible for the health services that it wants to integrate within the health districts.

The provincialisation of PPHC services is an important step toward creating this vertically integrated health system. By taking over PPHC services, the provincial health

department gains control over all aspects of facility-based health care services. Provincialisation creates the foundation for developing a vertically integrated health system in which lower- and higher-level health services are linked through a referral system. Patients would begin by consulting a primary health care nurse at a community health centre or a community health clinic and, if more specialised treatment is required, the patient would then be referred to the next level of care which is provided in a hospital.

In areas where provincialisation of PPHC services has occurred, implementing Healthcare 2010 should be easier. The key reason for this is that the implementation of Healthcare 2010 would not be dependent on intergovernmental negotiations. In the light of earlier discussions which highlighted the municipalities' negative response to provincialisation of PPHC services, one would expect that cooperation would not have been forthcoming from all municipalities in the non-metropolitan areas to give effect to Healthcare 2010. In the metropolitan area, where provincialisation of PPHC was not yet planned in the area, I noted in an earlier discussion that the two authorities had indicated that Healthcare 2010's implementation was subject to the existing cooperation agreement between MDHS and City Health.

In summary, the provincialisation of PPHC facilitates the implementation of the Western Cape Department of Health's plans for reorganising the health system. The idea of creating a seamless referral system is an important idea within the provincial health department based on various provincial health department sources. The provincialisation of PPHC services is important, because it maintains an important idea

within the provincial health department about the type of health system that the Western Cape Province needs.

## **6.5 Conclusion**

This chapter has presented the shift from a decision to decentralise PHC services to a municipality to a decision to centralise PPHC services under the authority of the provincial government as an instance of policy change. I demonstrate Hinnfors's (1999) point that policy decisions are sometimes taken to preserve the status quo. In this chapter I have demonstrated that a provincial government policy decision moved the approach to health system reform in the Western Cape Province away from national policy expectations, particularly as these related to the nature of health service integration and DHS governance. This was the basis for my claim that the policy decision to adopt provincialisation in the provincial health policy context is an indicator of policy change.

I have highlighted that the adoption of provincialisation should be understood as a policy change from below. The reason is that the provincial government's negotiated role with the national government was to be that of an implementer of health policy. It would therefore seem as if the PGWC had overstepped the boundaries within the public health policy context. However, when discussing facilitating conditions for policy change, I argued that provincial governments in South Africa are empowered in a number of ways, not the least of which is that their constitutional role is joint policy making with the national government with regard to health services. The important point is that we must examine what the decisions and activities at the implementation level mean in terms of national policy expectations.

A significant part of this chapter has entailed applying the persuasion framework developed in Chapter 2. From the policy literature I emphasised that policy change would occur to avoid significant losses. I contrasted mainly the financial implications of decentralisation relative to centralisation through provincialisation of PPHC services to demonstrate that the centralisation was the most cost-effective option. Furthermore, I identified two important ideas within the Western Cape Department of Health, namely that district health services should be the focus in health districts, and that the health system should be vertically integrated. When identifying district health services as a key theme within the Health Department, I used the organisational structure of the provincial Health Department as a guideline. I discussed how the provincialisation of PPHC services would contribute to maintaining these ideas as the basis for health system reform in the Western Cape Province.

This chapter has provided evidence that the PGWC had sufficient decision-making scope to adopt a decision such as provincialisation, which in its effects alters the national vision of a health system. This is evidence of policy change and this policy change was only relevant in the Western Cape Province. In this sense the PGWC did not overturn a national policy decision, but instead it chose a different route for health system reform. This alternative route was based on provincial government ideas and informed by their interests.

The second part of the persuasion framework consisted of an explanation of how policy change occurred. I apply the framework to make sense of how the provincialisation of

PPHC services became the preferred option above decentralising PHC services. In the next chapter I explain how policy change occurred in the Western Cape Province.

## **Chapter 7: Explaining policy change using the persuasion framework**

### **7.1 Introduction**

This chapter applies the theoretical framework explained in Chapter 2 to present a picture of how provincialisation of PHC services replaced the option to decentralise PHC services to municipalities. In the first part of this chapter I briefly introduce the key elements of the persuasion framework. These elements are John's (1998) key explanation for how policy change occurs and Bacchi's (1999) analytical concept of problem representation.

In the second part of the chapter I show that the link between ideas and interests, which John (1998: 166) argues is the basis for policy change, exists in the provincial health policy context. In the first part I describe the arguments in the Western Cape Department of Health's annual reports, statements and the MEC for Health's budget speeches between 2003 and 2006. These arguments from provincial health officials contain significant problem representations. I identified a policy advocate whose policy representation offers the most extensive insight into why decentralisation of PHC services did not occur and why provincialisation became the preferred policy solution for the PGWC. In the second part of this section I describe the problem representation that convinced provincial policy makers that provincialisation was the only suitable policy solution to the problems facing the Province in relation to health sector reform.

In section three of this chapter I discuss why the policy advocate's problem representation would have persuaded policy makers, meaning the MEC for Health and

the PGWC Cabinet, to adopt provincialisation. I conclude this chapter with a summary of how policy change occurred in this context.

## **7.2 Analytical tools for explaining how policy change occurs**

In order for policy change to occur there has to be a mechanism that leads to policy makers perceiving a particular situation as one which would lead to extensive loss. John explains policy change as a product of an evolutionary mechanism that “selects” some ideas above others (John, 1999: 48). He refers to two “selection mechanisms” in politics, the force of the argument in deliberation or public opinion, and the benefits accruing to a group or a policy entrepreneur (John, 1999: 48). Exploring arguments using Bacchi’s (1999) concept of problem representation is an important extension of John’s work, if we can demonstrate how this policy-change mechanism works. This means showing how policy advocates weave their ideas and interests together with those of the policy makers.

My work emphasises the persuasive capability of linking ideas and interests. This link is an argument that persuades policy makers that they are facing extensive loss. I apply Bacchi’s concept of problem representation to the material collected in this research. Bacchi (1999: 1) notes that every policy proposal has an “explicit or implicit diagnosis of the ‘problem’, or a ‘problem representation’.” Bacchi (1999: 2) argues that problem representations should not be viewed as solutions to problems, but as competing representations of political issues. These competing representations are narratives that are used to persuade.

A persuasive set of arguments links ideas and interests and can facilitate policy change. I explore this link through problem representations, because I want to identify the arguments used to convince policy makers to adopt provincialisation. The components of a persuasive problem representation are Policy Advocate (Interests and Ideas) + Policy Makers (Interests) = Facilitation of Policy Change.

Analysing the material collected for problem definitions is useful for two reasons. First, it offers a gateway for exploring the language used to persuade policy makers. Second, I can examine the problem representations to establish whether there was a policy advocate for provincialisation in the public health policy context. The policy advocate could offer a persuasive problem representation. I looked for interviewees who offered coherent narratives supporting provincialisation. The coherent narrative is the one that provides a fuller picture than the justifications in the provincial health department's documents such as the annual reports from 2002 onward and the MEC for Health's public statement on the provincialisation of PPHC services in 2005. As provincialisation of PPHC services benefits the Western Cape Department of Health, it is important to consider high-level officials in this department as possible policy advocates, because they have access to the MEC for Health and by implication also the PGWC Cabinet. This access can facilitate the ability to influence policy decision making.

Bacchi (1999) argues that we need to study problem representations, because they have effects. One such effect is that problem representations may produce silence, because a definition of a problem determines what will be discussed and in particular what will be

left out of a discussion (Bacchi, 1999: 2).<sup>130</sup> It is important therefore to ask what does the problem representation that supports provincialisation remove from the debate about establishing a DHS? To answer this question I also discuss a competing problem representation from those who argued against the provincialisation of personal primary health care services.

### **7.3 Identifying the policy advocate in the provincial health policy context**

One senior provincial health official indicated that he provided the logic that finally led to the adoption of provincialisation in the health policy context. If this were indeed the case, then the explanations that this senior health official offered would be part of a comprehensive and persuasive problem representation, which led to provincialisation being perceived as the best solution in the provincial health policy context in the Western Cape Province.

In this section I hold this senior provincial health official's problem representation against the explanations included in provincial health documents and the MEC for Health's statements on provincialisation in 2005. In the first section I note the range of justifications for provincialisation from various provincial health policy documents. In the second section I describe the key elements of the problem representation that the senior provincial health official offered.

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<sup>130</sup> Bacchi's (1999) concept of problem representation is based on the notion that a policy problem is a social construction. Coburn (1996: 343-344) notes that it is established in the literature that the way that policy problems are defined affect what is seen and what is ignored. So the way groups and individuals define problems would open the space for some solutions to be preferred above others, or as she puts it: problem definitions label some actions as legitimate and others not (Coburn, 1996: 344). Coburn (1996: 344) argues that problem framing has not been studied with respect to implementation in terms of asking "how local actors frame problems during policy implementation". I use an extended understanding of Bacchi's concept of problem representation to explore how the actors involved in, and related to, the implementation processes of health system reform in the Western Cape Province framed the problem of health service integration.

*Components of a 'problem representation': justifications for provincialisation*

Each justification is an argument that forms part of a problem representation. The first source for justifications for provincialisation is the Western Cape Department of Health's annual reports. The introduction to the annual report for the financial year 2003/2004 notes regarding provincialisation: "A decision was taken by the Provincial Government to provincialise primary health care services. This will result eventually in seamless health provision from clinic to hospital" (Western Cape Department of Health Annual Report, 2004: 2). Then under the discussion of Programme 2 there is the following:

Following exhaustive attempts to resolve the issue of around District Health system governance, the decision was taken to provincialise municipal personal primary health care services. This decision was reached following the proclamation by Minister for Provincial and Local Government, Mr Mufamadi, which confined Municipal Health Services to environmental health services.... The decision was also driven with the need for integration and improved effectiveness of the services (2004: 13).

According to this annual report, provincialisation was adopted because attempts to resolve DHS governance issues were not successful and the national minister defined municipal health services in a way that limited the role of municipalities to environmental health services. Provincialisation is presented as a response to a national policy decision that by implication left provincial governments responsible for all other health services.

Provincialisation was also associated with creating a vertically integrated health system, where the components of the system are linked from clinics to hospitals. Under the sub-heading, Programme 2, the annual report for the financial year 2004/2005 notes

that “The decision was taken also to provincialise the running of the District Health System which would improve efficiency of primary health care services” (Western Cape Department of Health Annual Report, 2005: 3). Furthermore, “the decision was taken to proceed with the provincialisation of the non-Metro Personal Primary Health Care services previously provided by Local Government following the provision of additional funding for this purpose by the National Treasury” (Western Cape Department of Health, 2005a: 3).

Then under the heading “Implementing the District Health System and divisional priorities” there is the following justification for provincialisation:

The provincialisation of personal primary health care is seen as the next step in the implementation of a District Health System. This process was set in motion in November 2003 when it became evident that the implementation of a District Health System, managed by local authorities, was proving untenable (Western Cape Department of Health Annual Report, 2005a: 20).

The document goes on to cite the main problems as being labour relations issues, which led to the failure of the Bi-Ministerial Task Team initiative and the failed transfer of PHC services to the City of Cape Town municipality. In this instance, provincialisation is associated with improved efficiency of primary health care services. This report suggests that provincialisation was adopted but not implemented, and then it was again up for implementation when the National Treasury made additional funds available for provincialisation. Finally, provincialisation is associated with creating a province-run DHS, because decentralisation was no longer an option as a result of the labour relations problems that had already hampered two attempts at decentralisation.

Apart from the justifications in the annual reports, the MEC for Health, Pierre Uys, also justified policy decisions in public statements and presentations to the legislature. In the Western Cape Health budget speech for the financial year 2005/2006 on 29 April 2005 the MEC for Health refers to provincialisation as a challenge in 2004 because of lack of funding to provincialise (Uys, 2005). In the Budget speech the MEC for Health once again noted that the National Treasury had provided funds, which they could now use to provincialise personal primary health care services in the non-metropolitan area, and that provincialisation is associated with a vertically integrated health system (Uys, 2005).

The PGWC Cooperative Governance Summit document (2003) also offers a justification for provincialisation in the health policy context. This document noted that uncontested functions, meaning functions that are deemed provincial government responsibilities such as primary health care services, are unaffordable for the PGWC government. Their affordability would also decrease when national government implemented a new funding formula and thus “a pragmatic approach needs to be developed to deal with the possible transfer and provincialisation of these functions” (2003: 16-17). The justification for provincialisation was thus financial.

In summary, justifications for provincialisation include the notions that decentralisation was no longer a viable option because of labour relations issues, and that provincialisation was on track again to be implemented after the National Treasury provided funding to implement the decision to provincialise PPHC service in non-metropolitan areas. Provincialisation was also justified based on the fact the PGWC did

not anticipate how it would be able to afford PPHC services along with the other services which are its responsibilities.

*The more extensive problem representation*

When analysing the interview material for problem representations I encountered a number of arguments which I identified as justifications for provincialisation in a senior provincial health official's explanation. The interviewee gave me permission to use a first name, but I have chosen to report the problem representation anonymously. The senior provincial health official offered the following explanations on the key aspects that I identified in the previous discussion.

Decentralisation did not occur after the Bi-Ministerial Task Team's recommendations and after the 2001 PGWC Cabinet decision for the following reasons:

The first and foremost thing is the Provincial Treasury...they have to sign the root form. They will not sign the delegation to local government. They will only sign what they call an assignment, which is what Constitution prescribes.

Number two, the disparities between salaries between provincial government and local government. Local government that time, this is before the Public Finance Management Act, the only thing they guarded was the issue around funded and unfunded mandates. They said this is an unfunded mandate. So we wanted to know do we provide funding for the staff that are going to transfer at your salary or at our salaries. Money and process, technical issues.... The City of Cape Town that time we worked out that apart from transferring those 2000 staff members, their accrued leave and their other benefits came to R54 million. So if we wanted to delegate this function we had to look for R54 million just to pay their accrued leave benefits...

But the third level issue you are raising is the issue of funding because, and I am talking about 2001, we went to tell Cabinet that the instruction you gave us cannot be implemented. The first reason we told them was that traditionally, your perception of district health system is not mine. Yours is primary health care, clinic services but that small bit of the service has traditionally been

funded by local government and provinces. The reason for the profile is because of the 1977 Health Act, which provided them the power to do it. That is the discrepancy between the 1977 Health Act and the 2003 Act. The 2003 Act now makes it explicit that province is responsible for the funding of district health services. The 1977 Health Act does not say that explicitly. It only says that at the time regional services councils, on an agency basis could provide a service for province. That is why we don't want a delegation with agency services, we've had bad experiences with running agency services.<sup>131</sup>

This quote highlights a fuller picture of the logic that informed provincialisation, even though the key focus here is on why decentralisation did not occur. There are a number of important points. First, the Provincial Treasury was not in favour of the type of decentralisation that the PGWC Cabinet envisioned and thus it was unwilling to approve it. Second, the health costs of the Western Cape Department of Health would increase if they decentralised. Then there was an issue with municipalities, because they said that primary health care services were an unfunded mandate and the provincial health department wanted clarity on the financial implications of this statement. Then the final issue was that the health department and the Cabinet had different ideas about what a District Health System means. This was related to different provisions in the pre-democratic South African Health Act of 1977 and the provision in the 2004 National Health Act. The official also noted also they were unwilling to back a system of delegation because past experiences were negative.

Senior provincial health official (1) argued that because national policy makers defined municipal health services as environmental health services, this meant that the nine provincial governments and the national government were now responsible for all health services that were not environmental health services.

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<sup>131</sup> Interview with a senior provincial health official (1), 72.

We told them that in 2003...when you made the definition of municipal health services, same time they promulgated that Municipal Finance Management Act and the Municipal Finance Management Act makes it clear that no local government can use ratepayers' money to fund a function that they are not accountable for.<sup>132</sup>

The justifications for provincialisation included the perception that defining municipal health services as environmental health services would create a financial problem for the PGWC. The reason for the financial problem is that financial management regulations, such as the Municipal Finance Management Act, which took effect in July 2004, would only allow municipalities to fund their own functions. This means that they expected that municipalities would argue that they are only financially responsible for environmental health services. This would have meant that the PGWC government needed additional funds to cover the full costs of personal primary health care services.

In summary, PHC services were not decentralised for a number of reasons: labour relations problems; an unwillingness by the Provincial Treasury to support the type of decentralisation that the provincial health officials were proposing; research indicated that decentralisation would bring increased costs for the PGWC; and finally, because the National Health Act (Republic of South Africa, 2004) makes provincial governments responsible for district health services and not primary health care services.

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<sup>132</sup> Interview with senior provincial health official (1), 72.

#### **7.4 Linking the policy advocate's problem representation with the policy makers' interests**

The main aim of this section is to demonstrate that the policy advocate developed a problem representation that spoke to the interests of the policy makers, which facilitated the adoption of provincialisation and thus produced policy change.

We established in the previous section that a senior provincial health official promoted provincialisation to the MEC for Health in the provincial health policy context as an alternative to transferring primary health care services to the City of Cape Town municipality. In the first discussion I present the policy advocate's problem representation. Then in the second discussion I demonstrate why this problem representation would have been convincing to the MEC for Health and the Provincial Cabinet.

##### *The policy advocate's problem representation*

What definition of the problem did the policy advocate present? In the discussion about health system reform in the Western Cape Province, the senior provincial health official noted a number of issues as having affected the way that health system reform unfolded. Some of these aspects I mentioned in the previous discussion, but there are additional significant factors that are mentioned as part of the problem of health system reform in South Africa. One was that the health legislation and the finance legislation were not aligned. Another is that local government does not have the capacity to provide district health services. Third, a district health system was only legally

established in 2003, when the National Health Act (Republic of South Africa, 2004) was passed.

According to the senior provincial health official, the key argument presented to management was that the PGWC became responsible for district health services when the national Minister for Provincial and Local government defined municipal health services as environmental health services. The implications of this decision were explained in the following way:

Look at the various chapters of the Constitution shows the functions of national, provincial and local government and the constitution defines local government functions in the... schedules. Schedules four and five it states if you look at it schedules four and five exclusive provincial legislative competence. There it says ambulance services. So it's not an issue of contestation, it's stated in the Constitution, there in schedule 4. There you have concurrent national/provincial legislation health services...Then it states except then part the following local government functions run by local government, and it states there municipal health services. That's an exclusive function of local government,... So I'm saying... that the problem is a funding issue... if you look at part B there's nothing,.....Constitution plus the act makes it very clear that all services except municipal health services are provincial competency.<sup>133</sup>

Thus this senior provincial health official argued that decentralisation was no longer an option because the national Minister for Provincial and Local Government had defined municipal health services as environmental health services. This definition of municipal health services was also in the National Health Act (Republic of South Africa, 2004: 14). The national minister thus defined the respective health functions of the spheres of government. The national and provincial governments are jointly responsible for health services. In effect the national minister gave provincial governments authority to decide whether they would decentralise or not. This was the basis for promoting

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<sup>133</sup> Interview with senior provincial health official (1), 72.

provincialisation within the provincial public health services in the Western Cape Province.

The second key component of this problem representation is that this definition of municipal health services creates a financial responsibility for the provincial government. This senior provincial health official argued that the municipality finance regulations do not allow the municipalities to continue funding personal primary health care services, because this is not their function. This would have created a picture of a provincial government that would be concerned about how they were going to fund PPHC services, because municipalities that were providing these services on behalf of the PGWC contributed to the subsidy they received from the provincial government.

According to senior provincial health official, this problem representation was offered to management in July 2003.

*The problem representation appeals to the provincial policy makers' interests*

The key question addressed here is why the policy advocate's problem representation was persuasive. If policy makers act to avoid "continual painful losses" (Welch, 2005), how were provincial policy makers convinced that they should adopt provincialisation? In other words, what kind of loss would convince the MEC for Health and the PGWC Cabinet that they should adopt provincialisation?

Decentralisation of PHC services would have constituted a major loss for the MEC for Health. As PPHC services were interpreted as a provincial government function, transferring service delivery downward would have meant transferring significant

amounts of funding and staff to designated municipalities. The MEC would therefore have been less in charge of his responsibilities than if primary health care services were run by the provincial health department only. Health planning would take place at the municipality level and the health staff would report to health management structures within the municipalities. The MEC for Health and the department which he oversees would be less involved in implementing primary health services. In fact, they would in effect only be managing different levels of hospitals.

If the PGWC Cabinet approved decentralisation, then the relevance of the regional health management structures within the Western Cape Department of Health could be questioned. If the PGWC decentralised PHC services they would transfer PPHC service provision and management out to municipalities. The MEC for Health would then effectively have a health department with regional health management offices where the majority of their management functions were contracted out. These agencies would then only be responsible for managing the district hospitals and other designated hospitals in the Western Cape Province. Decentralisation could therefore lead to arguments that the Western Cape Department of Health needs to be downsized.

In fact, the Local Government response paper (n.d.: 10) on the decision to provincialise uncontested functions argued that instead of asking municipalities to decrease their costs by 50%, the PGWC could address the issue of duplication that exists when there are regional health management offices and municipal health departments. The DHS is based on management at the health district level, which means in the South African context that health management should focus on the geographical areas within metropolitan and district municipality boundaries.

The policy advocate's interpretation of the implications of the Municipal Finance Management Act (2004) spoke directly to the PGWC Cabinet's interests. The policy advocate's arguments drew attention to the fact that the PGWC became fully financially responsible for all its functions when the Municipal Finance Management Act (MFMA) act came into effect in 2003. This means that the PGWC Cabinet would have to find funds to pay the full costs of PPHC services, library and museum services, amongst other services that municipalities provided on their behalf. At the time when the PGWC Cabinet was considering provincialisation, which is sometime in 2003, the National Health Act of 2004 had been passed, but was not yet in effect. The health act made provision to prevent disruption in health service funding because it obliged municipalities not to withdraw their contribution to PPHC services when the MFMA came into effect. The National Health Act (Republic of South Africa, 2004: 42), however, obligates municipalities to maintain their contributions until agency agreements between the municipalities and provincial governments are in place. However, by the time that the National Health Act came into effect in March 2005, the PGWC had already adopted provincialisation (in 2003) as a policy solution to the pending funding problem that they anticipated they would face based on the policy advocate's explanation of the implication of provisions in the municipal financial legislation.

Provincialisation also serves other interests of the PGWC Cabinet. It was significant for the PGWC Cabinet because it facilitated implementing PGWC Cabinet plans for economic development in the province, *Ikapa Elihlumayo* (The Growing Cape). The provincialisation of the uncontested functions would facilitate the implementation of

this strategy, because it aligned the reality of service delivery in the Western Cape Province with the constitutional responsibilities of the two spheres of government. In practical terms municipalities and the provincial governments are clear on their respective powers and functions. The PGWC argument was that if the municipalities and the provincial government fulfil their respective functions, they will contribute to development in the Western Cape Province (Cooperative Governance Summit, 2003).

Provincialisation needed to be discussed with the municipalities in terms of the cooperative governance framework in the South African Constitution (Republic of South Africa, 1996). While municipalities did not have the ability to counter a provincial government decision, they could attempt to derail implementation, as I indicated they had intended to do so in Chapter 5. Municipality councils, as the other health service authority in the province, are important policy actors. Provincialisation also spoke to municipality politicians' interests, because municipalities would be able to use the funds that they were contributing to PPHC services for other municipality functions. According to senior City Health official (1), municipality politicians were pleased with this outcome. He noted: "...you know, when they did it in the non-metro areas, they got clapped when they presented to all the mayors in the area because it's saving those councils sixty-five million rand a year, which they can redirect elsewhere of rates money."<sup>134</sup> This suggests that municipality policy makers were in favour of the provincialisation of uncontested functions such as PPHC services, library and museum services.

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<sup>134</sup> Interview 2 with senior City Health Official (1), 101.

Under the circumstances which the policy advocate defined, provincialisation seemed a much better option for both the MEC for Health and the PGWC Cabinet, as it minimised loss of control over a major part of health service delivery and over human and financial resources. For the MEC for Health provincialisation of PPHC services would also mean that this would establish the Western Cape Health Department as the key health service delivery authority in the Western Cape Province. This would mean that the provincial health minister's portfolio becomes more important, because the majority of people in the province were still dependent on public health services.

*The unpersuasive problem representation*

I will now consider why the problem representation offered by those who argued against provincialisation after November 2003 was not successful. The simple answer is that they did not speak to the interests of those who had the authority to decide about provincialisation. It is important to explore the kinds of arguments that were proffered, because they highlight the issues that were being contested within health system reform in the Western Cape Province.

The municipality component of the Working Group acted as policy advocate against provincialisation after the November 2003 Cooperative Governance Summit. It consisted of senior municipality officials such as municipal managers and the CEO of WECLOGO. The active advocacy of WECLOGO suggests that municipality politicians may have changed their minds about provincialisation, particularly in the health policy context, as this is what the Local Government Response paper argues (n.d.). WECLOGO was the representative of the municipalities in the Western Cape Province at the time.

Those who argued against the provincialisation of particularly PPHC services were attempting to convince PGWC politicians and senior health management that it was not an appropriate solution in the health policy context. These arguments included that the provincialisation of personal primary health care services was not in the interest of service delivery. The provincial government was too far away geographically to understand the local needs, the province was focused on curative services and this is likely to overwhelm a focus on preventative services, and they expressed the fear that rural communities could be marginalised (Local Government Response, n.d.: 5-6).

Furthermore, they argued that there is a higher level of accountability regarding delivery of personal primary health care services by local government, because local government councillors are closer to the communities and can address issues faster than the provincial government, which is accountable to the people through MEC for Health, something they describe as a “delayed and remote level of accountability” (Local Government Response, n.d.: 6). Other arguments included that horizontal rather than vertical integration of health services would be efficient, that alternative arrangements can create vertical integration of primary health care services with hospitals (Local government response, 2004: 6). A particularly important argument that they put forward is that “a significant amount of PPHC funds is spent in the regional structure of the Province”, which they describe as an expensive structure and add that a local government option would decrease expenses (Local Government Response, n.d.: 7).

The general response to the PGWC was that there was no good cause to justify the provincialisation of personal primary health care services. The municipalities, which aligned themselves with this response, were arguing that the ANC-run provincial government in the Western Cape Province was taking a decision that would lead to results that are contrary to national government health policy expectations.

However, in 2006 an interesting development occurred at the national health policy level. The National Health Council (NHC) endorsed the provincialisation of PPHC services in non-metropolitan areas in South Africa. This is significant, because the PGWC Cabinet decision taken in 2003 had become a national health policy decision in 2006. The difference, however, is that the National Health Council indicated that provincialisation would only be relevant to metropolitan areas if the provincial government and the metropolitan municipality were unable to reach an agreement.

The PGWC Cabinet decision to provincialise would be applied throughout the Western Cape Province. There is therefore another story to unpack. This story is based on the following question: why did the National Health Council take a decision to promote the provincialisation of PPHC services in the non-metropolitan areas in South Africa? Perhaps one hypothesis to test is the argument about the implications of the Municipal Finance Management Act. Unfortunately I cannot offer a more elaborate answer to this question as my research focused on health system reform in the Western Cape Province. I can only discuss what happened in the Western Cape Province in relation to debates at the national level about health system reform between the spheres of government.

### **7.5 Policy change as the effect of the politics of implementing health system reform**

Bacchi (1999) argued that we should examine problem representations as a gateway to understanding the politics of a situation. What do the problem representations for and against the provincialisation of PPHC services indicate were the politics around implementing a DHS in the Western Cape Province?

The problem representations offered by those who argued for and against provincialisation in the public health context highlighted two different visions for health system reform. Those who argued in favour of provincialising PPHC services supported the integration of PPHC services with hospitals. In other words, they argued for creating a vertically integrated health system. They also supported the idea that the PGWC should become the authority over the DHS in the Western Cape Province. Those who argued against provincialisation supported integrating PPHC services with environmental health services, which would lead to a horizontally integrated health system. Furthermore, they supported the idea that local government should be the authority over the DHS.

These different visions reflect the respective positions in a long-standing debate within the national health policy context about who should be responsible for the DHS. Responsibility for the DHS is also intimately tied to who is responsible for PHC services. Bachmann and Makan (1997: 724) noted that provincial and local government had been fighting about who should manage PHC services since 1995. The respective health functions of the three spheres of government were only clarified in 2002 with Minister Mufamadi's proclamation. This means that for seven years there was tension between the provincial and local government because the national government had not

clarified the functions of the spheres of government, which were vaguely defined in the South African Constitution.

The politics surrounding DHS implementation in the Western Cape Province may also be associated with national-level developments, which may have been interpreted as threatening to their existence. For example, IMATU official (2) noted that the trade unions were planning to contest provincialisation in court, because they believed it to be part of a national government plan to incorporate municipalities into the public service.

On the other hand, we can also understand the decision to provincialise an important policy matter such as PPHC services in the light of a debate initiated by the National Department of Provincial and Local Government regarding whether South Africa needs provinces. These questions are significant when one considers that the ANC's representation in the South African Parliament is often close to the two-thirds majority which is needed for constitutional change. Furthermore, as the ANC has governed either seven or eight out of nine provinces in South Africa since 1994, constitutional change is not unlikely. As my research was primarily focused on developments in the Western Cape Province, I cannot say with certainty that the contestation around provincialisation of PPHC services also was a response to developments at national government level.

The final point about the politics of implementing a DHS in the Western Cape Province was that the different visions tell us that the debate about who should be responsible for the DHS reflects a power contest between the provincial and local government. The

PGWC won this round in the Western Cape Province when it stuck with its decision to provincialise PPHC services. Provincial government also won out over municipalities when the National Health Council recommended the provincialisation of PPHC services in non-metropolitan areas in South Africa.

## **7.6 Conclusion**

In this chapter I demonstrated how policy change occurred in the health policy sector in the Western Cape Province. The basis for explaining policy change was John's (1998) point that policy change occurs when a policy advocate links his idea/ideas and interests to policy makers' interests. I used Bacchi's (1999) concept of problem representation to demonstrate how a policy advocate is able to persuade policy makers to adopt a particular policy solution. This allowed me to identify the argument that was used to persuade policy makers and I could then contrast the argument with the interests of the policy makers. I used Welch's (2005) arguments that decisions are taken to avoid continuous painful losses as the basis for identifying policy makers' interests. I compared what the decentralisation of PPHC services would have meant for the MEC for Health and the PGWC Cabinet. I contrasted these prospective outcomes with that of provincialisation of PPHC services. I concluded that provincialisation outweighed decentralisation in benefits for those who had the authority to take a decision about whether to decentralise or provincialise.

One of the main challenges when applying John's idea about the mechanism that creates policy change is that it was difficult in this instance to identify a policy advocate, because provincialisation was the policy solution to different problems. I overcame this problem by firstly describing the arguments from provincial health

annual reports and the MEC for Health's budget statements. These documents were the basis for the analysis of particularly provincial health official explanations of why the decision to decentralise PHC services to the City of Cape Town municipality was not taken and why the decision to provincialise PPHC services was taken. I identified the policy advocate as the official who offered the most extensive explanation for both decisions.

Instead of only applying John's idea about how policy change occurs, I also discussed why the argument from those who were contesting provincialisation did not speak to the interests of the provincial policy makers. The important persuasive elements in the argument made to promote provincialisation were that it offered the PGWC Cabinet a means to secure an important place in the health policy sector. The policy advocate also highlighted a pending financial problem and offered a viable solution to that problem. The arguments made against provincialisation could be interpreted as a challenge to the PGWC's authority to take such decisions, particularly in the health policy context where national health policy goals would not be fulfilled. An important point here is that these arguments suggested that there are different perspectives on the scope that the PGWC Cabinet had to take decisions on health policy matters.

In this chapter I demonstrated that problem representations may be considered as more than just a definition of a problem. They may also be seen as arguments that are used to persuade policy makers to adopt particular policy solutions. The adopted policy solution could facilitate a deviation from existing policy expectations because it realises alternative policy goals and thus leads to policy change. Policy change should be

viewed as another material effect of a problem representation within public policy processes.

The next chapter concludes this dissertation with a summary of the argument and the evidence.

## **Chapter 8: Conclusion**

### **8.1 Introduction**

This dissertation has demonstrated how we can learn about how policy change ‘from below’ by studying the decisions taken and the activities that occur during implementation. Through utilising insights from, amongst others, Barrett (2004), Mosse (2004, 2005) and Pretorius (2003), I was able to think more critically about the role of policy and implementation in policy processes, and how decisions and activities at the level of implementation can signal policy change.

In this chapter I review the key aspects in this dissertation. I begin with a summary of the research question and the research findings. Following this is a description of the key aspects of the persuasion framework and a brief description of the insights obtained into implementation processes from applying this framework. I then present some key future research themes on the implementation of health system reform in South Africa.

### **8.2 The research question and the main findings**

This research began as a case study on a particular aspect of the implementation of a DHS in the Western Cape Province. The research aim was to explain why the PGWC Cabinet decision to decentralise PPHC services to the City of Cape Town municipality was not implemented. In public policy implementation terms I was exploring why there was an implementation gap. As much research has been done on implementation gaps over three decades of implementation research, the broader theoretical aim of the research included examining the material from the case study on the implementation gap with a view to understanding implementation processes better.

The core finding from this research was that the decentralisation did not take place because, amongst other factors, policy change was pending. I arrived at this finding based on the observation that health system reform differed in a significant way between the metropolitan area and the non-metropolitan areas of the Western Cape Province. There were more activities aimed at implementing functional integration in the metropolitan area than in the non-metropolitan area initially, but this changed when the provincialisation of PPHC services became the tool for reform, as implementing provincialisation was limited to the non-metropolitan area during my fieldwork period. These different pictures highlighted a lack of uniformity in the implementation of health system reform in the Western Cape Province.

The implementation gap thus existed because provincial policy actors had changed their minds about how the integration of health services should proceed throughout the Western Cape Province. Based on this finding, the lack of implementation could not be interpreted simply as a signal of failure. Instead, when I continued to examine what happened after attempts to implement the initial policy decision had stopped with the Health Services Task Team report in 2002, I found decisions and activities that indicated that change was pending. The provincial government had decided to integrate personal primary health care services through centralisation rather than decentralisation. This decision was important, because it perpetuated established ideas within the Western Cape Department of Health and it re-established the provincial government in the Western Cape Province as the key public health service provider in the province. Thus policy change was in this case working to maintain a long-standing status quo.

Policy change was initiated through a PGWC decision to take over personal primary health care services from municipalities. The takeover process was referred to as provincialisation. A significant point from this case was that the provincialisation of PPHC services had been on the PGWC agenda since 2003 and it was announced as a health policy decision in 2005. The significant aspect about provincialisation was that it changed the way that things worked in the province and it was a product of the interpretation of changes in the national “policy space” (Majone, 1989). The National Health Act came into effect in 2005 and the already established financial regulations for provincial and local government were interpreted in a way that indicated that provincialisation was the most appropriate solution.

The decision to provincialise PPHC services would realise alternative policy goals to those implied in national health policy expectations. It would establish a province-run DHS instead of a municipality-run DHS, and it created a vertically integrated health system where PPHC services are integrated with different levels of hospitals. This is contrary to national policy expectations of horizontal integration, where PPHC services are integrated with environmental health services.

### **8.3 The persuasion framework as an alternative lens on implementation**

The key question that led to the development of the persuasion framework was: how does one explain an implementation gap once a provincial government had changed its collective mind about how health system reform would occur in the province? I aimed to explain why and how policy change occurred in the Western Cape Province. This

section briefly summarises the core elements of the persuasion framework. I also discuss the utility of this framework when applied to this case.

The persuasion framework addresses the following question: how does one conceptualise the relationship between policy implementation research, which tends to focus on whether policy is being translated into practice, and policy change research, where the primary concern is explaining why certain significant policy decisions are taken? It is an interpretive tool, which bridges the division between themes studied in public policy implementation studies, such as implementation gaps, and themes that public policy researchers examine in their attempts to develop a general theory of public policy processes, such as policy change.

The persuasion framework explains policy change as follows: policy change occurs when a policy advocate, which could be an individual or a group, creates a “problem representation” (Bacchi, 1999: 1). I extended the meaning of a problem representation to include a definition of the problem, a policy solution and an argument that supports the understanding of the problem and the policy solution. The problem representation integrates the policy advocate’s ideas and interests with the policy makers’ interests, which entail avoiding “continual painful losses” (Welch, 2005: 8). The problem representation is viewed as the tool of persuasion, because it presents the proposed policy solution as the only alternative.

The framework explored a number of questions which aim to unpack whether the environment was fertile for policy change. The first question was whether facilitating factors were present. I examined the scope for taking decisions about how health

system reform would be implemented. To measure the scope for decision making, I examined the extent of decentralisation in the South African government system and within the public health policy sector. The second question was whether there was sufficient motivation for initiating policy change. I explored whether national policy expectations challenged established ideas within the provincial health department and whether these expectations raised concerns about interests which could be negatively affected by changing the status quo. The motivations reflect both organisational interests and self-interest.

Applying this framework to the data meant analysing the data for a persuasive problem representation. This problem representation would be the one that persuaded the policy makers that the proposed policy solution is the best solution. In other words, it meant searching for a problem representation that creates the impression that not adopting the proposed policy solution could lead to significant loss. The problem representation is then tested against the arguments in various data sources that explain why the particular policy solution was adopted. The problem representation that offers the most comprehensive explanation is viewed as the most likely to be the one that persuades decision makers. A comprehensive explanation would show that the problem representation presents a coherent narrative that integrates a range of arguments in favour of the proposed policy solution. It is assumed that if these arguments were persuasive, they would appear in other data sources such as government documentation.

The persuasion framework allowed me to develop an account giving an insight into the implementation of health reform policy in the Western Cape Province. In Chapters 4

and 5 I described health system reform initiatives in the metropolitan and the non-metropolitan area. These chapters document the decisions and the activities related to implementing a DHS. I then argued in Chapter 6 that the implementation gap was not a signal of failure, because new policy solutions were legitimately adopted and I concluded that this was a signal that change was pending.

By applying this framework I was able to explain in Chapter 7 why provincial policy makers changed their minds about decentralising personal primary health care services. I could also gain an insight into why provincialisation was adopted. By analysing the material for problem representations, I located two sets of justifications for the provincialisation of personal primary health care services. One set emanated from within the Western Cape Department of Health and the other from the PGWC Cabinet and was related to a plan for economic development in the Western Cape Province.

I highlighted the politics of implementing health system reform in the Western Cape Province when I noted that provincial and municipal managers were arguing for health service integration based on two different interpretations of what national policy expectations were. These competing interpretations of national health policy were arguments about health service integration and these arguments were related to which sphere of government should be responsible for the DHS. The ‘winning’ interpretation, the one that supported the provincialisation of personal primary health care services in the Western Cape Province, was selected because it was a persuasive package of arguments that would ultimately benefit those who had the power to take health policy decisions for the Western Cape Province. The persuasive problem representation was identified in Chapter 7.

The persuasion framework was developed through a case study on the implementation of health system reform policy. The facilitating factors, the motivations and the mechanisms that lead to policy change are all general elements that may be explored in other contexts. The government system may affect the utility of the framework. If there is little or no legitimate scope within the government system and the policy sector for implementers to adopt alternative policy solutions, then one could argue that failed implementation is an appropriate interpretation. However, when one works with the use of discretion, this could be a basis also for establishing whether discretionary decisions lead to policy change.

As this is the first presentation of the persuasion framework, it needs to be applied in other policy sectors and other governing contexts and it also invites critique in order to develop.

#### **8.4 Questions for future research on transforming the health system in South Africa**

When I ended my fieldwork in April 2006, the provincialisation of PPHC services was being implemented in the non-metropolitan municipal area. One of the key arguments against the provincial government taking over PPHC services was that this would negatively affect health service delivery. It is therefore important to examine the implications of provincialisation for health service delivery in the Western Cape Province.

The national government adopted provincialisation as an interim strategy. There are a few research questions here. Why did the national government adopt provincialisation for primary health care services? How are the other eight provinces in South Africa implementing provincialisation? Are there similarities in terms of implementation strategies, the contestations that existed between the provincial government and the municipality, and was provincialisation also a strategy aiming to secure a broader provincial government economic development vision.

The future vision for health system transformation is still to have a decentralised health system and there is a constitutional imperative in South Africa for decentralising services. It is therefore important to examine whether the PGWC and any other provincial government in South Africa which provincialised personal primary health care services will take the initiative to transfer personal primary health care service delivery or the health function to municipalities in the respective provinces.

## **8.5 Conclusion**

A key characteristic of policy implementation is that implementation outcomes often do not conform to policy expectations. Instead of always interpreting a mismatch as signalling failure, I argue that we should examine whether implementation gaps are not signalling policy change in some instances. In this concluding chapter I summarised the account of reinterpreting implementation gaps as signals of policy change.

## **Bibliography**

African National Congress. (1994) *Reconstruction and Development Programme*. Johannesburg: Umanyano Publications.

Arskey, P. and Knight, P. (1999) *Interviewing for social scientists: an introductory resource for examples*. London: SAGE Publications.

Atkinson, S. (2002) Political cultures, health systems and health policy in *Social Science and Medicine*, 55: 113-124.

Bacchi, C. L. (1999) *Women, Policy and Politics: the construction of policy problems*. London: SAGE Publications.

Bachman, M. O. and Makan, B. (1997) Salary inequality and primary care integration in South Africa in *Social Science and Medicine*, 45(5): 723-729.

Barrett, S. (2004) Implementation Studies: time for a revival? Personal reflections on 20 years of implementation studies in *Public Administration*, 82(2): 249-262.

Barron, P. and Asia, B. (2001) The District Health System. Ntuli, A. (ed.) (2001) *South African Health Review 2001*. Durban: Health Systems Trust.

Barron, P. (2005) The District Health System in the health district of the City of Johannesburg. Background paper prepared for the Gauteng Health Department and the City of Johannesburg. Unpublished paper.

Baxter, J. and Eyles, J. (1997) Evaluating qualitative research in Social Geography: establishing 'rigour' in interview analysis. *Transactions of the Institute of British Geographers*. New Series. Vol. 22 (4): 505 - 525.

Bennet, C.J. and Howlett, M. (1992) The lessons of learning: reconciling theories of policy learning and policy change. *Policy Sciences*. Vol. 25: 275-294.

Boland District Municipality (2004) Delivery of Personal Primary Health Care (PPHC) Services. 12 July 2004. Reference number: Fin 5/1/1/3-CF.

Bossert, T. (1998) Analysing the decentralisation of health systems in developing countries: decision space, innovation and performance in *Social Science Medicine*, 47(10): 1513-1527.

Brown and Stewart Jr. (1993) Advocacy coalition: policy evolution and airline deregulation. Sabatier, P. and Jenkins-Smith, H. (ed.) 1993. *Policy Change and learning: an Advocacy Coalition Approach*. Boulder: Westview Press.

Cameron, R. (1996) Local government boundary demarcation: the case of the Western Cape metropolitan area substructures. *Politikon*. Vol. 23 (1): 21-42.

Cape Winelands District Municipality (2005a) Meeting on personal primary health care services. 20 May 2005. Response to the Office of the Premier, Western Cape Province,

on the meeting set for Thursday 26 May 2005 at 11:00 at M-2 boardroom, 7 Wale Street, Cape Town.

Cape Winelands District Municipality (2005b) Annual Report 2004/2005. Cape Winelands District Municipality.

Cape Winelands District Municipality (2006) Request: transfer PPHC staff to PGWC. Reference number: 7/2. 26 January 2006.

CHSO. (2003) *Community Health Service Organisation Annual Report 2002-2003*. Provincial Government of the Western Cape Department of Health. <[http://www.capecapegateway.gov.za/Text/2004/3/chso\\_annual\\_report\\_2002\\_3.pdf](http://www.capecapegateway.gov.za/Text/2004/3/chso_annual_report_2002_3.pdf)>

(14/02/05)

Cline, K. D. (2000) Defining the implementation problem: organizational management versus cooperation, in *Journal of Public Administration Research and Theory*, 10 (3): 551-571.

Coburn, C.E. (2006) Framing the problem of reading instruction: using frame analysis to uncover microprocesses of policy implementation. *American Educational Research Journal*. Vol. 43 (3): 343-379.

Colebatch, H.K. (2006) What work makes policy? *Policy Sciences*, 39: 309-321.

Cooperative Governance Summit (2003) Motivation and recommended resolutions for the Western Cape Co-operative Government Summit. 7 November 2003. Stellenbosch.

Cooperative Governance Summit Working Group (2003) Co-operative Governance Summit Working Group meeting: senior provincial and municipal officials. 27 November 2003 in Swellendam. Unpublished document.

Cooperative Summit Workgroup (2004) Proforma function description. Arrangement of functions between province and municipalities. Preparatory framework and request for information. 19 January 2004. Prepared by the provincial component of the task team.

de Leon, P. (1999a) The missing link revisited: contemporary implementation research. *Policy Studies Review*. Vol. 16 (3/4): 311- 338.

de Leon, P. and de Leon, L. (2002) Whatever happened to policy implementation? An alternative approach, in *Journal of Public Administration Research and Theory* 12(4): 467-492.

Denzin, N.K. and Lincoln, Y.S. (eds.) (2003) *Collecting and Interpreting Qualitative Materials*. Thousand Oaks: SAGE Publications.

Department of Health and Social Services (2000) Report of the Bi-Ministerial Task Team on the implementation of a municipality-based District Health System. Provincial

Administration of the Western Cape.

<[http://capegateway.gov.za/eng/publications/reports\\_research/R/3186](http://capegateway.gov.za/eng/publications/reports_research/R/3186)> (21/09/2009)

Department of Health (PGWC) (2006) Vote 6.

<[www.gateway.gov.za/Text/2006/2/vote\\_06.pdf](http://www.gateway.gov.za/Text/2006/2/vote_06.pdf)> (24/01/2007)

Department of Health (national) (2001) Budget speech by Minister of Health, Dr Manto Tshabalala-Msimang, at the NCOP, 12 June 2001.

<<http://www.info.gov.za/speeches/2001/0106131045a1003.htm>> (02/09/2007)

Doherty, J., Kraus, R. and Herbst, K. (1996) *Health Facilities*. South African Health Review: Health Systems Trust. < <http://www.hst.org.za/publications/208>>

Dowding, K. (2000) How not to use evolutionary theory in politics: a critique of Peter John. *British Journal of Politics and International Relations*. Vol. 2(1): 72-80.

Fischer, F. (2003) *Reframing Public Policy: discursive politics and deliberative practices*. New York: Oxford University Press.

Fontana, A. and Frey, J.H. (2003) "The interview: From Structured Questions to Negotiated Text", in Denzin, N.K. and Lincoln, Y.S. (eds.). *Collecting and Interpreting Qualitative Materials*. Thousand Oaks: SAGE Publications.

Forman, L., Pillay, Y. and Sait, L. (2003) *Health Legislation 1994-2003*. South African Health Review: Health Systems Trust.

<[http://www.hst.org.za/uploads/files/chap2\\_03.pdf](http://www.hst.org.za/uploads/files/chap2_03.pdf)> in HST (2003) South African Health Review 2003/04 <<http://www.hst.org.za/publications/423>> (18/11/04)

Galvin, M. and Habib, A. (2003) The politics of decentralisation and donor funding in South Africa's rural water sector, in *Journal of Southern African Studies*, 29(4): 865-884.

Grin, J. and van de Graaf, H. (1996) Implementation as communicative action. *Policy Sciences*. Vol. 29: 291-319.

Goggin, M. L. (1986) The "Two few cases/too many variables" problem in implementation research, in *The Western Political Quarterly*, 39(2): 328-347.

Goldstein, J. and Keohane, R. O. (eds.) (1993) *Ideas and Foreign Policy: an analytical framework*. Ithaca: Cornell University Press.

Grossman, M. (2005) Role Theory and foreign policy change: the transformation of Russian foreign policy in the 1990s. *International Politics*. Vol. 42: 334-351.

Hall, P.A. (1993) Policy paradigms, social learning, and the State: The case of economic policymaking in Britain. *Comparative Politics*. Vol. 25 (3): 275-296.

Harrison-Migochi, K. (1998) Priority programme implementation. Ntuli, A. (ed.) South African Health Review 1998. Durban: Health Systems Trust. <<http://www.hst.org.za/publications/210>> (21/09/2009)

Health Services Task Team (2002) Health Services Task Team draft final report. 20 March 2002. Unpublished report.

Hoberg, G. (1996) Putting ideas in their place: a response to 'Learning and Change in British Columbia Forest Policy Sector'. *Canadian Journal of Political Science*. Vol. 29 (1): 135-144.

Human Resources Task Team (2005) 'Minutes of the Human Resources Task Team (HRTT) meeting regarding the transfer of the personal primary health care services (PPHC) from local authorities to the Provincial Government Western Cape held at the Local Authority Bargaining Council Offices in Parow on 11 May 2005' attached with SALGA Circular number 64 of 2005.

Heywood, A. (2007) *Politics 3<sup>rd</sup> Edition*. Hampshire: Palgrave Macmillan.

Hicklin, A. and Godwin, E. (2009) Agents of change: The Role of Public Managers in Public Policy. *The Policy Studies Journal*. Vol. 37 (1): 13-20.

Hill, H. (2003) Understanding Implementation: Street level bureaucrats resources for reform, in *Journal of Public Administration Research and Theory*, 13(3): 265-282.

Hill, M. and Hupe, P. (2002) *Implementing Public Policy*. London: SAGE Publications.

Hill, M. and Hupe, P. (2009) *Implementing Public Policy*. 2<sup>nd</sup> Edition. London: SAGE Publications.

Hinnfors, J. (1999) Stability through change: The Pervasiveness of Political Ideas, in *Journal of Public Policy*, 19(3): 293-312.

Howlett, M. and Ramesh, M. (2003) *Studying Public Policy: policy cycles and policy subsystems*. Ontario: Oxford University Press.

Human Resources Task Team (2005) Minutes of the Human Resources Task Team (HRTT) meeting regarding the transfer of personal primary health care services (PPHC) from local authorities to the Provincial Government Western Cape held at the Local Authority Bargaining Council offices in Parow on 11 May 2005.

Hyder, M. (1984) Implementation: the evolutionary model. Lewis, D. and Wallace, H. (ed) (1984) *Policies into practice: national and international case studies in implementation*. London: Heineman.

John, P. (1998) *Analysing Public Policy*. London: Continuum.

John, P. (1999) Interests, ideas, agendas and implementation: an evolutionary explanation of policy change in British Local Government finance, in *British Journal of Politics and International Relations*, 1(1): 39-62.

John, P. (2000) The uses and abuses of evolutionary theory in political science: a reply to Allan McConnell and Keith Dowding. *British Journal of Politics and International Relations*. Vol. 2 (1): 89-94.

John, P. (2003) Is there life after Policy Streams, Advocacy Coalitions, and Punctuations: Using evolutionary theory to explain policy change? *The Policy Studies Journal*. Vol. 31 (4): 481- 498.

Kahn, T. (2004) Treasury calls for rethink on health funding. Business Day, 1 November 2004. <[www.hst.co.za/news/item.php?nws\\_id=20040555](http://www.hst.co.za/news/item.php?nws_id=20040555)> (02/02/2007)

Kelly, J. (1990) *Finding a cure: The Politics of Health in South Africa*. Johannesburg: South African Institute of Race Relations.

Keeley, J. and Scoones, I. (2000) Environmental policy making in Zimbabwe: discourses, science and politics. IDS Working Paper 116.

Koslowski, R and Kratochwil, F.V. (1994) Understanding change in international politics: the Soviet empire's demise and the international system. *International Organization*. Vol. 48 (2): 215-247.

Kotzé, HJ (1989): 'Aspects of the public policy process in South Africa' In Venter A (ed.) (1989) *South African Government and Politics: an introduction to its institutions, processes and politics*. Johannesburg: Southern Book Publishers.

Legal Advisor (2004) Local Governance in the Western Cape: note regarding the principle of subsidiarity as introduced in Section 156(4) of the Constitution. Unpublished document.

Lipsky, M. (1980) *Street-level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

Litvak, J. Ahmad, J. and Bird, R. (1998) *Rethinking decentralisation in developing countries*. World Bank: Sector Studies Series 21491. Washington: The International Bank for Reconstruction and Development/The World Bank.

Local Government Discussion Document (2004) Local Government Discussion Document: a municipal mandate. 'Motivation and recommended resolutions for the Western Cape Co-operative government summit', dated 7 November 2003. 24 February 2004.

Local Government Response (n.d.) Local Government response to the document titled 'Motivation, and recommended resolutions for the Western Cape Co-operative Government Summit, 7 November 2003'.

Lowry, W.R. (2008) Can Bureaucracies Change Policy? *The Journal of Policy History*. Vol. 20 (2): 287-306.

Lundin, M. (2007) Explaining cooperation: How resource interdependence, goal congruence and trust affect joint actions in policy implementation. *Journal of Public Administration Research and Theory*. Vol. 17: 651-672.

Majone, G. 1989. *Evidence, argument and persuasion in the policy process*. Michigan: Yale University Press.

Matland, R. E. 1995. Synthesizing the Implementation Literature: The Ambiguity Conflict Model of Policy Implementation, in *Journal of Public Administration and Research Theory*, 5(2): 145-174.

Mawhinney, (1993) Advocacy coalition approach to change in Canadian education. Sabatier, P. and Jenkins-Smith, H. (ed.) 1993. *Policy Change and learning: an advocacy coalition approach*. Boulder: Westview Press.

May, P.J. and Winter, S.C. (2007) Politicians, managers and street-level bureaucrats: influences on policy implementation. *Journal of Public Administration and Research Theory*.

Mazmanian, D. A. and Sabatier, P. (1989) *Implementation and Public Policy*. Lanham: University Press of America.

McIntyre, D, E. and Doherty, J.E. (2004) Healthcare financing and expenditure – progress since 1994 and remaining challenges. Van Rensburg, H.C.J. (2004) *Health and Health Care in South Africa*. Pretoria: Van Schaik Publishers.

McIntyre, D. and Gilson, L. (2000) Redressing disadvantage: Promoting Vertical Equity within South Africa, in *Health Care Analysis*, 8: 235-258.

McIntyre, D. and Klugman, B. (2003) The human face of decentralisation and integration of health services: experience from South Africa, in *Reproductive Health Matters*, 11(21): 108-119.

McGrath, R. J. (2009) Implementation theory revisited...*Again*: Lessons from the State Children's Health Insurance Program. *Politics and Policy*. Vol. 37 (2): 309-336.

MDHS. (2003) *Strategic Plan*. Provincial Government of the Western Cape. Cape Town: Department of Health.

MDHS. (2004) *Metropole District Health Services Annual Report 2003/2004*. Provincial Government of the Western Cape. Cape Town: Department of Health.

MDHS. (2005) *Metropole District Health Services Annual Report 2004/2005*. Provincial Government of the Western Cape Department of Health: MDHS. <[http://www.capegateway.gov.za/Text/2005/10/annual\\_report\\_2004-2005\\_2005-09-20.pdf](http://www.capegateway.gov.za/Text/2005/10/annual_report_2004-2005_2005-09-20.pdf)> (21/09/2009)

Ministry of Health (1997) White paper on the transformation of the health system in South Africa. <<http://www.info.gov.za/whitepaper/1997/health.htm>> (18/11/04)

Mishler, E.G. (1990) Validation in Inquiry-Guided Research: The Role of Exemplars in Narrative Studies, in *Harvard Educational Review*, 60(4): 415-442.

Mjekevu, T. (1996) *District Systems Development*. South African Health Review: Health Systems Trust. <<http://www.hst.org.za/uploads/files/sahr96.pdf>>

Mosse, D. (2004) Is good policy unimplementable? Reflections on the ethnography of Aid policy and practice, in *Development and Change*, 35(4): 639-671.

Mosse, D. (2005) *Cultivating Development: an ethnography of Aid policy and Practice*. London: Pluto Press.

Nakamura, R. (1987) The textbook policy process and implementation research. *Policy Studies Review*. 7(1): 142-154.

Neuman, W.L. (2000) *Social research methods: qualitative and quantitative approaches*. 4<sup>th</sup> Edition. Needham Heights: Allyn & Bacon.

Nijzink, L. and Jacobs, S. (2000) Provincial elections and government formation in the Western Cape: the politics of polarisation. *Politikon*. 27(1): 37-49.

Nohrstedt, D. (2005) External shocks and policy change: Three Mile Island and Swedish Nuclear Policy, in *Journal of European Public Policy*. 12(6): 1041-1059.

Ntuli, A. and Day, C. (2004) Ten years on: have we got what we ordered? In Health Systems Trust. 2004. South African Health Review 2003/2004. <<http://www.hst.org.za/publications/423>>

O'Toole Jr. L.J. (2000) Research on Policy Implementation: Assessment and Prospects. *Journal of Public Administration Research and Theory*. Vol. 10 (2): 263-288.

O'Toole Jr. L.J. (2004) The theory-practice issue in policy implementation research. *Public Administration*. Vol. 82 (2): 309-329.

Owen, C.P. (1995). *A policy for the development of a District Health System in South Africa*. Pretoria: Department of Health: Health Policy Coordinating Unit.

Parsons, W. (1995) *Public Policy: an introduction to the theory and practise of policy analysis*. Cheltenham: Edward Elgar.

Peterson, K. (2001) A Comprehensive Primary Health Care service package for South Africa. Pretoria: National Department of Health.

Pillay, Y. (2001) The Impact of South Africa's new constitution on the organisation of health services in the post-Apartheid era, in *Journal of Health Politics, Policy and Law*, 26(4): 747-766.

Pillay, Y.; Leon, N.; Wilson, T.; Asia, B.; Barron, P. and Dudley, L. (2003) *Guidelines for functional integration: a key strategy towards the full implementation of the District*

*Health System. South Africa Department of Health.*  
 <<http://www.doh.gov.za/docs/factsheets/guidelines/dhs/intergration.pdf>> (17/04/05)

Powell, D.M. (ed.). (2001) *South Africa's Three-Sphere System: The Challenges for Governance*. Cape Town: Idasa.

Power, D. and Robbins, D. (1996) *Organisation and Management: Public Sector*.  
 South African Health review: Health Systems Trust.  
 <<http://www.hst.org.za/uploads/files/sahr96.pdf>>

Pressman, J.L. and Wildavsky, L. (1984) *Implementation: how great expectations in Washington are dashed in Oakland; Or why it's amazing that federal programs work at all. This being the saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes*. 3<sup>rd</sup> Edition. Berkeley: University of California Press.

Press release on the meeting between the executive Mayor of the Cape Winelands District Municipality and the MEC: Health in the Western Cape Province, Mr Pierre Uys held on 17 January 2006.

Pretorius, L. (2003) Six contributions for understanding gaps between policy and implementation: an overview, in *Politeia*. 22(1): 6-21.

Province of the Western Cape (2000) Western Cape Determination of Types of Municipalities Act. Act 9 of 2000. Provincial Gazette.

Provincial Government of the Western Cape. (2003) Co-operative Governance Summit on a healthy and pragmatic interaction between provincial and local government in the Western Cape Province, 7 November 2003. Invitation from MEC for Local Government, J.J. Dowry to executive mayors and municipal management in the Western Cape Province. 31 October 2003. Reference number: 19/24/1

Provincial Government of the Western Cape. (2004) Western Cape Medium Term Budget Policy Statement 2004-2007.  
 <<http://www.capegateway.gov.za/Text/2004/8/mtbps0407.pdf>> (24/01/2007)

Provincial Technical Team (2006) Provincialisation of PPHC services. Meeting held in Boardroom Stellenbosch Protea Hotel on 19 January 2005.

Ragin, C. (1992) Introduction: "What is a case?". in Ragin, C. and Becker, H. (ed) (1992) *What is a case?* Cambridge: Cambridge University Press.

Republic of South Africa. (1949) Prohibition of Mixed Marriages Act. Act 55 of 1949.

Republic of South Africa. (1950) Group Areas Act. Act 41 of 1950.

Republic of South Africa. (1977) Health Act 63 of 1977. 17 May 1977.

Republic of South Africa (1996) The Constitution of the Republic of South Africa. Act 108 of 1996.

Republic of South Africa (1998) To provide for the transfer of certain employees from a provincial administration to designated municipalities; and to provide for matter connected herewith (Transfer of Staff to Municipalities Act). Act 17 of 1998. Government Gazette: 27 May 1998. No 18929 (Number 746)

Republic of South Africa. (1999) Public Finance Management Act. Act 29 of 1999.

Republic of South Africa. (2000) Ministers Authorisations to Category B municipalities for water, sanitation, electricity and municipal health in terms of the Municipal Structures Act (as amended) 2000, 7 November 2002. <<http://www.info.gov.za/speeches/2002/02111814461004.htm>> (19/11/06)

Republic of South Africa. (2004) *National Health Act*. Act 61 of 2003. Government Gazette: 23 July 2004. No. 26595 (Number 869)

Robichau, R.W. and Lynn, Jr., L.E. (2009) The implementation of Public Policy: Still the missing link. *The Policy Studies Journal*. Vol. 37 (1): 21-36.

Sabatier, P. and Jenkins-Smith, H. (ed.) (1993) *Policy Change and learning: an Advocacy Coalition Approach*. Boulder: Westview Press.

Saetren, H. (2005) Facts and myths about research on Public Policy Implementation: Out-of-Fashion, Allegedly Dead, But Still Very Much Alive and Relevant. *The Policy Studies Journal*. Vol. 33 (4): 559 - 582

Schlager, E. and Blomquist, W. (1996) A comparison of three emerging theories of the Policy Process. *Political Research Quarterly*. Vol. 49 (3): 651-672.

SLSA Team (2003) Decentralisation in practice in Southern Africa. *IDS Bulletin*. Vol. 34 (3): 79 – 96.

South African Local Government Association (SALGA) (2005) Provincialisation of personal primary health care services [non-metropolitan municipalities]. Circular number 64 of 2005. Reference number: /mm20/7/1.

South African Local Government Association (SALGA) (2005) Primary health care: survey of basic conditions of service. Circular number 65 of 2005. 20 May 2005.

South African Local Government Association (SALGA) (2005) Provincialisation of personal primary health care services (non-metropolitan municipalities). Circular number 66 of 2005. 25 May 2005. Reference number: /ta – 20/7/1.

South African Local Government Association (SALGA) (2005) Provincialisation of personal primary health care services [non-metropolitan municipalities]. Circular number 70 of 2005. 1 June 2005. Reference number: /mm – 20/7/1.

Schofield, J. (2001) Time for a revival? Public policy implementation: a review of the literature and an agenda for future research, in *International Journal of Management Reviews*, 3(3): 245-263.

Schofield, J. (2004) A model of learned implementation. *Public Administration*. Vol. 82 (2): 283-308.

Schofield, J. and Sausman, C. (2004) Symposium on implementing public policy: learning from theory and practice introduction. *Public Administration*. Vol. 82 (2): 235-248.

Shore, C. and Wright, S. (1997) *Anthropology of policy: critical perspectives on governance and power*. London: Routledge.

Silverman, D. (2003) "Analyzing Talk and Text", in Denzin, N.K. and Lincoln, Y.S. (eds.). *Collecting and Interpreting Qualitative Materials*. Thousand oaks: SAGE Publications.

Stake, R.E. (2003) Case Studies. In Denzin, N. K. and Lincoln, Y. (2003) *Strategies of qualitative enquiry*. 2nd Edition. Thousand Oaks: Sage publications.

Steinmo, S. (2003) The evolution of policy ideas: tax policy in the 20<sup>th</sup> century. *British Journal of Politics and International Relations*. Vol. 5 (2) 206-236.

The Local Government and Health Consortium (2004) Decentralising health services in South Africa: constraints and opportunities. September 2003 - a crosscutting report. <[http://www.hst.org.za/uploads/files/lghcc\\_report.pdf](http://www.hst.org.za/uploads/files/lghcc_report.pdf)> (22/02/05)

Thomas, S., Mbatsha, S., Muirhead, D. and Okorafor, O. (2004) *Primary Health Care Financing and need across health districts in South Africa*. Local Government and Health Consortium. <<http://www.hst.org.za/uploads/files/phcfin.pdf>> (22/02/05)

Uys, P. (2005) Western Cape Department of Health Provincial Budget Vote 2005/2006. <<http://www.info.gov.za/speeches/2005/05050610451004.htm> > (06/03/2007)

Van Rensburg, H.C. and Harrison, D. (1995) *History of Health policy*. South African Health Review. Health Systems Trust. <<http://www.hst.org.za/uploads/files/sahr95.pdf>> (09/01/05)

Van Rensburg, H.C. (ed.) (2004) *National Health Care Systems: structure, types and dynamics*. Pretoria: Van Schaik Publishers.

Van Rensburg, H.C. (ed.) (2004) *The Health Professions and Human Resources for health-status, trends and core issues*. Pretoria: Van Schaik Publishers.

Van Rensburg, H.C. (ed.). (2004) *Primary Health Care in South Africa*. Pretoria: Van Schaik Publishers.

Van Rensburg, H.C. and Pelsler, A.J. (eds.). (2004) *The Transformation of the South African health system*. Pretoria: Van Schaik Publishers.

Van Rensburg, H.C.J. (2004) *The History of Health Care in South Africa*. Pretoria: Van Schaik Publishers.

Van Zyl, A. (2003) The Fiscal Autonomy of Provinces in the 1996 Constitution and in Practise, in *Politeia*, 22(1): 22-37.

Walt, G. (1994) *Health Policy: an introduction to process and power*. London: ZED Books.

Walker, L. and Gilson, L. (2004) 'We are bitter, but we are satisfied': nurses as street-level bureaucrats in South Africa. *Social Science and Medicine*. Vol. 59: 1251-1261.

Welch, M. (2005) *Painful Choices, a theory of foreign policy change*. New Jersey: Princeton University Press.

Western Cape Department of Health. (2002) *The case for change! A brief introduction to healthcare 2010, a conceptual framework for change*. Western Cape Department of Health. [http://us-cdn.creamermedia.co.za/assets/articles/attachments/00306\\_introhealthcare2010.pdf](http://us-cdn.creamermedia.co.za/assets/articles/attachments/00306_introhealthcare2010.pdf)

Western Cape Department of Health. (2003) *HealthCare 2010: Health Western Cape's plan for ensuring equal access to quality health care*. Cape Town: Department of Health (PGWC).

Western Cape Department of Health. (2003) *Annual Report of the Western Cape Department of Health*. Western Cape Department of Health. [www.gateway.gov.za/eng/pubs/annual\\_reports/2003](http://www.gateway.gov.za/eng/pubs/annual_reports/2003) (20/09/2009)

Western Cape Department of Health. (2004) *Annual Report of the Western Cape Department of Health 2003-2004*. Provincial Government of the Western Cape Department of Health: Department of Health. <[www.gateway.gov.za/eng/pubs/annual\\_reports/2004](http://www.gateway.gov.za/eng/pubs/annual_reports/2004)> (20/09/2009)

Western Cape Department of Health (2004) Filling of posts within primary health services. Cape Town: Department of Health. 8 April 2004.

Western Cape Department of Health. (2005a) *Annual Report of the Western Cape Department of Health 2004-2005*. Cape Town: Western Cape Department of Health. <[http://www.capegateway.gov.za/Text/2005/10/annual\\_report\\_2004-2005\\_2005-09-20.pdf](http://www.capegateway.gov.za/Text/2005/10/annual_report_2004-2005_2005-09-20.pdf)> (21/09/2009)

Western Cape Department of Health. (2005) Provinces to take over primary health care facilities run by municipalities. Statement by Department of Health: Western Cape Provincial Government: 11 March 2005. <<http://www.capegateway.gov.za/eng/pubs/news/2005/mar/101417>> (15/01/07)

Western Cape Department of Health (2005) Memorandum of understanding. Reference number: 7/2/1/3.3300

Western Cape Department of Health (2006) Personal Primary Health Care Agreement. 10 January 2006.

Western Cape Department of Health (2006) *Annual Report of the Western Cape Department of Health 2005-2006*. Cape Town: Department of Health.

Western Cape Department of Local Government. (2003) *Department of Local Government: strategic plan 2003/2004-2005/2006*. <[http://www.capecgateway.gov.za/Text/2003/wc\\_local\\_govt\\_stratplan.pdf](http://www.capecgateway.gov.za/Text/2003/wc_local_govt_stratplan.pdf)> (21/09/2009).

Western Cape Department of Local Government and Housing (2004) Annual report for the financial year 2003-2004. <[www.capecgateway.gov.za/eng/pubs/annual\\_reports/2004](http://www.capecgateway.gov.za/eng/pubs/annual_reports/2004)> (20/09/2009)

Western Cape Department of Local Government (2004) Co-operative Governance Summit Working Group: Local Government Discussion Document. 8 April 2004.

Western Cape Department of Local Government (2004) Filling of vacancies in respect of health, roads, library and museum services. 19 April 2004. Reference number: 19/25/1.

Western Cape Department of Local Government. (2004) Meeting between WECLOGO and the Minister of Local Government and Housing on Wednesday, 8 December 2004. Reference number: LG10/4/1/7/1.

Western Cape Department of Health (2006) Summary Draft Comprehensive Service Plan.<[http://www.capegateway.gov.za/other/2006/9/summaryserviceplan\\_sept\\_06\\_15.pdf](http://www.capegateway.gov.za/other/2006/9/summaryserviceplan_sept_06_15.pdf)>

Western Cape Local Government Organisation (WECLOGO) (2003) Proposed memorandum of understanding. Circular number 7 of 2003. 27 January 2003. Annexure 3.

Western Cape Local Government Organisation (WECLOGO) (2003). Co-operative Government Summit and municipal and provincial powers and functions. Circular number 89 of 2003. 11 November 2003.

Western Cape Local Government Organisation (WECLOGO) (2004) Filling of posts. 2 April 2004.

Western Cape Local Government Organisation (WECLOGO) (2004) Proposed Subsidiarity Exercise. 7 April 2004.

Western Cape Local Government Organisation (WECLOGO) (2004) Subsidiarity exercise. To: Members [and advisers] of the municipal component of the task team appointed after the co-operative governance summit. 7 April 2004.

Western Cape Local Government Organisation (WECLOGO) (2004) Proposed subsidiarity exercise and interim agreement. 7 April 2004.

Western Cape Local Government Organisation (WECLOGO) (2004) Request for meeting with Provincial Cabinet: health burden on municipalities. 14 May 2004. Reference: KG NICOL/mm-20/7/1.

Western Cape Local Government Organisation (WECLOGO) (2004) Meeting of the municipal component of the Cooperative Governance Summit Working Group: 25 May 2004: Kleinmond. To: Members [and advisers] of the municipal component of the task team appointed after the co-operative governance summit. 18 May 2004. Reference: KG NICOL/mm-4/3/1.

Western Cape Local Government Organisation (WECLOGO) (2004) Co-operative Governance Summit Working Group. To: Members [and advisers] of the municipal component of the task team appointed after the co-operative governance summit. 26 May 2004. Reference: KG NICOL/mm- 4/3/1.

Western Cape Ministry of Local Government. (2004) The “functions and powers” – dilemma between provincial and municipal spheres of government: moving ahead. 2 June 2004. Reference number: S/12/2/1/3.

Western Cape Ministry of Health (2005) Primary health: Provincial versus Local Government. 21 July 2005. Reference number: 3/1/R.

WHO (1978) Alma Ata Declaration.  
<[http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)> (23/04/05)

Winter, G. (2000) *A comparative discussion of the notion of 'Validity' in Qualitative and Quantitative research*. <<http://www.nova.edu/ssss/QR/QR4-3/winter.html>> (10/01/05)

Yanow, D. (1978) Criticisms: what implementation research has not taught us? *Policy Studies Review*. Vol. 7(1): 103-115.

Yanow, D. (1993) The communication of policy meanings: implementation as interpretation and text. *Policy Sciences*. Vol. 26: 41-61.

Yin, R.K. (2003) *Case Study research: design and methods, 3<sup>rd</sup> Edition*. Thousand Oaks: SAGE Publications.