District-based Health Services

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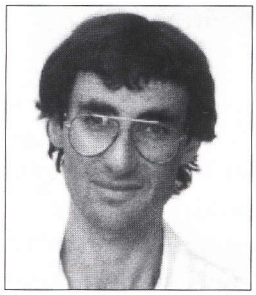

Curriculum Vitae

Dr Blecher qualified at the University of Witwatersrand in 1983. He worked for several years at community health centres in Crossroads and Duncan Village and in the Unit of Family Medicine/Primary Care, University of Cape Town. He is based in the Department of Community Health but is currently seconded to the Western Cape Provincial Administration, to work with various roleplayers in facilitating the development of health districts in the Cape Metropole area. He is married to Salma and they have two children.

Summary

South Africa's health services are currently being restructured in terms of the health district model. This should have numerous benefits especially in promoting the Primary Health Care approach, equitable resource distribution, rational planning, improved accountability and more comprehensive health services. Particular challenges ahead include determining district boundaries, building up capacity at district level, decentralising authority, integrating our previously fragmented health services and developing and implementing appropriate district health plans.

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Introduction

District based health systems are widely used by countries attempting to follow a Primary Health Care approach, and are strongly promoted by the World Health Organisation (WHO)[1-6]. Many South Africans are familiar with the British health system, which is based on the district model, and some have experiences of health districts in developing countries.

What are districts

The following definition of a district was adopted by a WHO subgroup in 1986[1]: "A district health system based on Primary Health Care is a more or less **self-contained segment of the national health system**. It comprises first and foremost a **well-defined population living within a clearly 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. Its component elements need to be well co-ordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities."

Let us examine some of these concepts in more detail.

1. **Self contained segment of the national health system**
   The national and provincial levels of government have in many countries (particularly those which are geographically large or have large populations) been too far from the community level to be responsive to local needs. It is recognised that many functions of government can be more effectively managed by decentralising them to smaller geographic and administrative entities called districts (these may in certain cases by the local level of government). In the health district model the entire country becomes subdivided into several hundred manageably sized and geographically coherent and contiguous districts. District health authorities are responsible for managing health services for the population resident in the district, with the provincial and national levels providing overall support and guidelines.

2. **Clearly defined geographical area**
   This is a central feature of the district. The health services of that area have a responsibility to serve a well defined group of people living in a clearly delineated and functionally coherent area. This population focus is very useful from a primary health care (PHC) perspective as it allows one to examine epidemiologically the health problems in the district, and facilitates efficient and rational planning, and service delivery.

3. **Well co-ordinated or managed by assigned officers**
   The district needs a dedicated management team to function effectively. This team needs to plan, manage, budget, develop health information systems, etc.

4. **Health in homes, schools, work places and community**
   One of the big advantages of the district based approach is that health interventions can be co-ordinated and integrated over a range of health facilities and relevant community settings. For example, a district programme to address TB can be conducted in clinics, hospitals, schools, work places, etc.

A district is a more or less self-contained segment of the national health system.

Why districts?

There are several reasons why there has been an international move towards district-based health systems.

1. **Community oriented primary care**
   The district approach helps to realise many of the essential PHC principles. The defined population base of the district promotes a meaningful assessment of the community's demographic, morbidity and mortality profiles, and favours community participation and rational planning.

2. **Democracy**
   Democratic principles are frequently interpreted to include bringing government closer to the people so

that local communities have more control over their lives. In South Africa, with a long history of lack of accountability, the establishment of democratic accountable government and services is important.

3. **Efficient management**
Management is frequently more efficient and effective when decentralised to the local level. This is because local management may be more in touch with local problems and rapid changes, and because large bureaucracies can be avoided.

4. **Integration rather than fragmentation**
Internationally within the PHC literature there has been much discussion about the advantages and disadvantages of selective versus comprehensive approaches to PHC. The selective approach is characterised by multiple vertical programmes (malaria, tuberculosis, family planning, sexually transmitted diseases, etc), each with their own administrative infrastructure, budgets and staff (often from national level down). Generally this approach has fallen into disrepute for a variety of reasons, and a comprehensive integrated approach is preferred. One of the advantages of the comprehensive approach is that it enables the district authority to assess the particular health problems in the district and to allocate resources and manage services in a more integrated way. This does not mean that job specialisation may not occur at district level.

In South Africa fragmentation has abounded - on racial grounds, between different tiers or government, between preventive and curative services and between many programmes. A large number of authorities provide health services in one area and these are frequently poorly co-ordinated, duplicative and wasteful.

Often national or provincial levels of government have been too far from the community to be responsive to local needs.

Establishment of health districts

1. **District size and boundaries**
There are many factors to be considered when determining the boundaries of districts. Since districts must be contiguous (ie their

borders must touch each other), the boundaries of individual districts cannot be determined in isolation.

International experience suggests that a health district should serve approximately 100 000 to 400 000 people. [1,2] Districts should not be too small, since it is inefficient to have a management team, health information system etc for every small town and suburb, and since the provicial level can only support a limited number of districts effectively. Districts should not be too big for reasons of democratic acccountability and efficient management described above. In particular if they are too big they become too far removed from the community.

Health district boundaries should ideally coincide with the administrative boundaries of other sectors. Intersectoral collaboration is an essential component of PHC because so many of the determinants of health lie outside the health sector. Newell expresses it well[3] "it is absurd to suggest that every sector of the public service should have different boundaries even if the ideal sectoral criteria for shape and size might differ. The result would be chaotic if health had one boundary, water and sanitation another, policing another, and so on." It is thus advisable for district boundaries not to cross local government boundaries, but it is acceptable to group a number of smaller authorities into one district. Local authority boundaries in South Africa are currently being redrawn in terms of criteria in the Interim Constitution and Local Government Transition Act. Sensible determination of these boundaries could greatly facilitate the development of districts.

Other factors to be considered in determining district boundaries include: geographic and physical boundaries eg mountains and rivers, infrastructure eg roads, population density, economic viability of the proposed districts and the nature of existing health services and hospital drainage areas. Boundaries should not divide cohesive communities, and the political process and involvement of all role players is clearly important.

2. Governance of health districts

Districts could fall under provincial government, under local government or be independent from both. Internationally there are many examples of all of these models, and each has advantages and disadvantages.

With a history like ours, a democratic accountable health service is essential.

Health services are listed in schedule 6 of the interim constitution which invests considerable legislative authority of health service provision in the hands of the new provinces. Provision is made in the constitution for local authorities to be given certain areas of responsibility. However, both the provincial and local government options for providing district health services are constitutionally possible.[7]

3. Training and support

Appropriate training for all categories of health worker in the district is essential. Training district management teams is especially important when establishing health districts. In many countries it has taken five to 10 years to firmly establish the foundations of health districts. It is important for provincial health administrations to restructure themselves to play this capacity building and supportive role.

Technical support programmes should, where appropriate, be established at provincial or regional levels to ensure continuity of support and training for previously vertical and new programmes to address priority health problems

4. **Formation of district committees** The formation of interim district co-ordinating or steering committees and joint planning can greatly assist in bringing together fragmented parts of the health services, non-governmental organisations (NGOs), private or independent practitioners and communities, and in promoting the relationships and trust necessary to achieve successful integration and co-ordination of services.

Functioning of health districts

There are many tasks which the functioning district health authority must carry out. These include providing the full range of community and primary level services including promotive, preventive, curative and rehabilitative services. In most countries the district includes a district level hospital providing non-specialist medical services. In addition the district health authority is responsible for managing, planning, budgeting, assessing the health needs and health status of the district, evaluating programmes, developing health information systems, etc. Each of these is a substantial area requiring more detailed analysis than space allows here.

Districts must be contiguous: their borders must touch each other and the boundaries cannot be decided on in isolation.

Health policy developments in South Africa

Within South Africa there has been considerable discussion and effort devoted to promoting and establish a district-based health service.[8-16] Prior to our first democratic elections it was already clear that the health plan of the African National Congress and the Reconstruction and Development Plan were substantially based on a district model, with the three levels of the health service being stated as national, provincial and district. Since the election, Minister Zuma and the Department of Health have stated repeatedly that our new health system will be based on the district model. Committees have been established at national, provincial and local levels and

Training district management teams is important but may take five to 10 years.

tremendous activity and interest have been focussed on this area over the past year.

Conclusions

Restructuring towards a district based system is one of the most important innovations South Africa's health sector has ever undertaken. The new system should prove a significant improvement on the old, but will require careful planning and the input of all health workers. It is time to begin detailed planning for the establishment of health districts in all parts of South Africa.

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Comments

Restructuring towards a district-based health system is one of the most important innovations South Africa's health sectors has ever undertaken.

The article by Blecher and Frankish on A District Health System for South Africa is indeed welcome as it once more focuses on the need for as many people as possible to think and plan for the future health needs of South Africa. They have rightly emphasised the importance of determining the optimum size of a district.[1,2] Many different models have been proposed, from small communities of 1 000 to 10 000 people to large regions comprising up to 1 000 000 inhabitants. If one of the aims of decentralisation is to promote responsibility and accountability, smaller rather than larger districts are more logical, particularly in a country in which small socio-cultural groups exist. The present health "wards" in our rural areas may form a convenient basis from which to develop the district model, while larger areas as advocated by Tollman et al[3] are probably too big.

Conyers, Cassels and Janovsky[4,5] have correctly identified the lack of managerial skills (as opposed to administrative skills) as one of the

biggest challenges of implementing district health systems. This may necessitate a gradual, piecemeal decentralisation with delegation of specific responsibilities from provinces to districts as skills are developed, in addition to intensive training programmes for managers.

Efficient decentralisation needs an effective system of audit across the whole spectrum of health delivery, financial control and management. This can occur on three levels - internal audits, provincial inspections and independent external audits (to ensure rapid, up-to-date reports).

Blecher and Frankish's approach is from the viewpoint of the health planner. The needs, opinions and inputs of patients, grassroots health care workers and community organisations also need to be addressed.

Finally, to quote Newell again[6] "A peripheral village-based tier of health services is acceptable only if it is both an integral part of the community it serves and is intimately linked with the next tier of services above it", including emergency services, a functioning referral system and effective intersectoral interaction.

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