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SOME PROBLEMS ASSOCIATED WITH THE Management of Primary Health Care Districts

At present most of South Africa is divided into Health Wards based mainly on existing rural hospitals. It is proposed to reorganise these areas into Health Districts as suggested by the World Health Organisation (WHO) in 1988.

The existing administrative structures are centrally controlled by a top heavy bureaucracy with a resulting loss of authority, accountability and initiative at the local level. A planned programme of decentralisation would thus be of prime importance in any revision of the present organisation.

Unfortunately, the quality of care delivered at all but the tertiary institutions leaves much to be desired and apart from a lack of human and material resources poor management is largely responsible.

Some Common Problems

1. ***Inadequate Management Training***
   Most hospital Superintendents acquire their status by default and find themselves in charge of a large hospital with a not inconsiderable budget with only a professional background and no management skills whatsoever. There is furthermore no planned formal training for managers, and even if there were it would be difficult to find the time to attend courses.

2. ***An Inadequate Data Base***
   Rural health facilities have as a rule very limited information about the demographics of their area, about their budgets, cash flows, expenditure patterns and personnel requirements – all essential for proper planning and management.

3. ***Inadequate Support Personnel***

- *Professionals.* The recruitment and retainment of health professionals, doctors in particular, has always been one of the major constraints in providing health care in underdeveloped areas and has been the subject of much study in other countries, notably in Canada and Australia. In this country there has been a number of commissions whose recommendations have been carefully filed and lost in the bureaucratic morass.

- *Administrative Cadres.* In the "homelands" where there has been a great deal of inappropriate affirmative action, the administration of health services has often been entrusted to poorly trained and unmotivated clerks prematurely promoted. This has meant that the hospital Superintendent has to step in and do many of these administrative tasks himself.

- *Nursing Staff.* By far the greatest burden of running the health services has fallen on the nurses who have by and large achieved much success. They are however greatly constrained by a very strong professional hierarchy which stultifies initiative and creativity.

- *Overcompartmentalised professions.* This prevents a gynaecologist from doing a herniorrhaphy although this may have been part of his training. It prevents nurses from doing things which are traditionally considered to be "doctor" tasks. Administrators are therefore compelled to appoint more staff than would be needed if personnel could be trained for specific tasks around their basic professional training.

4. Finance

- *Crazy Budgeting.* The present system of budgeting "by objectives" does not work because different people see their objectives differently. There is thus the tendency for administrators to place budget items under a variety of headings making comparisons impossible. It is quite insane that the largest components of the budget should be "other expenditure" and "miscellaneous"!

* *Crazy Budgeting II.* Even if an administrator tries to budget realistically his estimates will be cut completely haphazardly by a central authority which has no knowledge of the local needs.

- *Top Heavy Salary Expenditure.* Salaries account for over 65% of the budgets of many health facilities. Many of the employees are suboptimally productive and unmotivated. Local management has no disciplinary powers, certainly not the right to hire and fire.

* *No Control over Allocation of Expenditure.* Having carefully monitored one's expenditure one often finds that "someone at Head Office" had reallocated an item to a vote which is already overspent.

- *Adequacy of Financing.* It has been said that most rural health facilities would have adequate funds if waste could be reduced. In fact it would be difficult to use more funds appropriately without buying inappropriate expensive equipment.

- *Comparisons with other Countries.* According to UNICEF South Africa spends more per capita on health than many poorer countries, yet the standard of health as measured by conventional health indicators is lower. We are obviously wasting our resources!

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5. *Inefficient Centralised Administration*

- *Duplication of Administrative Processes.* Because of frequent errors in the records of the central bureaucracy (eg salary and leave records, details of expenditure, cash flows etc) records have to be duplicated locally. Since all major decisions are made at central level but accountability is at local level, the duplication cannot be avoided unless authority, decision making and responsibility9 are completely decentralised. Tremendous savings could be effected by reducing the central bureaucracy. It is evident that an efficient system of auditing could avoid malpractices at the local level while completely eliminating those occurring in a large anonymous organisation with accountability only to "another committee".

- *Cumbersome Data Processing.* In the TPA for example, the processing of salaries involves many different departments. Each item on the salary slip is calculated by another section. So files are shuffled back and forth thus compounding errors. In a decentralised situation all the calculations could be done by one department. The best monitor of any errors is the employee himself and any mistakes could be corrected immediately. At present, hospital

management spends many hours and innumerable telephone calls arguing about errors.

- *Time Wasting.* It takes some 14 or 15 different decision making processes before a new piece of equipment can be bought, by which time the price of the article has usually increased considerably.

6. ***Traditional Practices.*** The traditional training of doctors teaches them to make diagnoses by a process of exclusion and thus involves more investigations than may be necessary. Apart from over investigating, overservicing is a common practice. In the private sector where financial gain may be a motive these practices are common and have established a "norm" which has filtered into the public sector. Health administrators have a constant battle to train medical staff to contain costs by eliminating unnecessary investigations and reducing expensive treatment s of doubtful value.

7. ***Drug Supplies***. The supply of drugs to peripheral hospitals and districts has always been a major concern of health administrators. Too much valuable time is spent at all levels of health to try to contain costs, organise efficient distribution and counteract some of the unrealistic propaganda of drug companies. It is interesting to note that there are far fewer problems with the logistics of other supplies!

8. ***Demotivation of Personnel***. In the present political climate in South Africa health workers at all levels experience a great deal of uncertainty and insecurity. Superimposed on the pre-existing concepts that health services "belong to and are the responsibility" of the Government and that local management has no powers and no authority, the present uncertainty has so demotivated staff that they are fertile ground for those advocating strikes and unrest.

At any attempts to try to improve the quality of health care in rural areas will have to address some or all of these problems and in particular will have to engender, in local communities and in health workers a sense of Ownership and the feeling that a successful service must depend on the involvement of those who will benefit from the service.

It is evident that in addition to the other components of an efficient District Health Service, Decentralisation must be a key element. The degree to which it may be possible to decentralise must be the subject of detailed study and planning. It may well be that a greater measure of decentralisation than that advocated in the WHO model and in the current proposals of the various political parties could be possible.

Previous attempts at decentralisation have merely paid lip service to the concept and have only managed to add additional links to an already cumbersome chain, because decision making and power were kept by the central authorities. It is interesting to note that when health services in the rural areas were rendered by Mission Hospitals they had almost total autonomy. Funds were provided, although parsimoniously, by the Central Provincial Governments, and apart from salary scales which were centrally determined, local managers had complete control.

Proposals

That a study project be set up to examine:

- the feasibility of identifying two or three health districts which could be studies in depth,
- the applicability of existing concepts of "District Health Systems" in providing Primary Health Care in the Southern African context,
* the problems which beset health managers in remote areas,
- the possibility of creating completely decentralised administrations in these areas, perhaps using different models,
- the degree to which local communities could be given ownership,
- the size and form of the ideal health district,
- the relationship of health districts to regional and central health authorities,
- and evaluate inter sectoral involvement.
* If this was one it will be possible to formulate a model which could be applied to other areas.