Developing district health systems in the rural Transvaal

Issues arising from the Tintswalo/Bushbuckridge experience

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Abstract **District health systems are increasingly acknowledged as a foundation for national health services based on primary health care. Initial efforts to institute a demonstration district health system in the Bushbuckridge area of the eastern Transvaal are described. These include efforts to overcome the organisational and administrative fragmentation caused by homeland and provincial boundaries. Close attention needs to be given to district-level health management, the complementary roles of district and regional health authorities, working relationships and accountability among professional staff from different disciplines, involvement of the community in a district health authority and the district health system as an element of local government.**

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The 'district', an organising, planning and administrative concept, is widely recognised as a key element in the development of comprehensive health systems. With the experience of the 15 years since the Alma Ata declaration on primary health care,[1] the district level approach is increasingly viewed as indispensable to the effective implementation of primary health care. This view is expressed in the recent literature of the World Health Organisation,[2] and is central to emerging World Bank literature concerned with the development of health services in Africa.[3]

In South Africa, a number of recent meetings have affirmed a pivotal role for the district.[4-7] It is seen as the most peripheral unit of government, furthest from central authority and closest to local communities. It is therefore an essential bridge between the regional and national health policy levels, and the local implementation level. It is 'often the natural meeting point for "bottom-up" planning and organisation and "top-down" planning and support; a place where community needs and national priorities can be reconciled'.[8]

Less widely appreciated is the fact that district health systems are an aspect of local government, a subject of considerable importance in South Africa today.[9] This is partly because local (or district) government is where democracy begins: it is the level of government closest to the people, where elected representatives are known and communities can insist that local leaders fulfil campaign pledges and remain responsive to local community needs. District health services are therefore a component of a much broader movement towards the decentralisation of governmental authority and responsibility.

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The district concept is valid in urban, peri-urban and rural areas, developed and developing countries.[2,8] In South Africa's homelands, health wards that contain elements relevant to district health functioning have been created. For example, a single authority is responsible for both curative and preventive/promotive health services within a ward. Moreover, health wards have defined borders and thereby localise geographically the communities for which local services are responsible.

Unfortunately, ward boundaries are a subdivision of homeland boundaries and as such are subject to the same politically motivated geographical and political considerations; issues of health service functioning are of secondary importance. As a result, the potentially favourable circumstances just noted are seriously undermined by political and administrative realities.

Context: the Tintswalo/ Bushbuckridge area

Fig. 1 shows the Bushbuckridge area which covers approximately 1 250 km² and has a population of about 500 000 people. It is bounded by the north-eastern escarpment of the Drakensberg mountains to the west, the Kruger National Park to the east, the Hoedspruit farming area to the north, and Hazyview to the south.

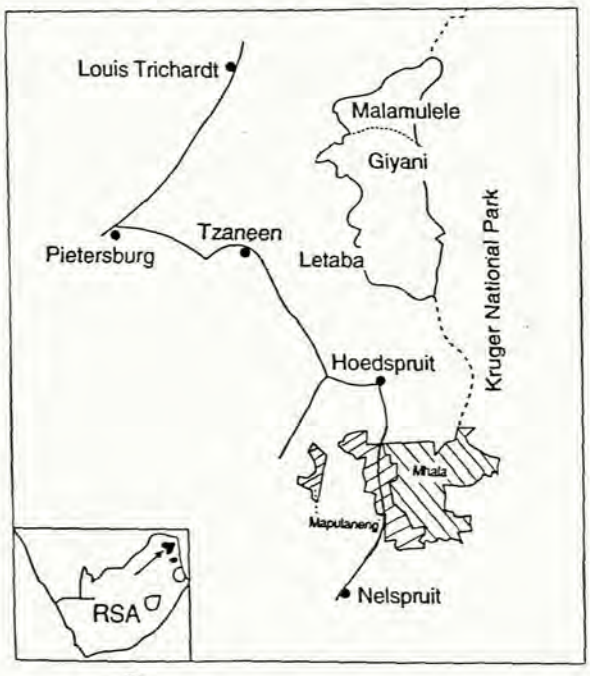

FIG. 1.
Map of the eastern Transvaal showing the Mhala and Mapulaneng health wards of the Bushbuckridge area.

Superimposed on this single geographical entity are sharply differentiated political and administrative units. The area contains two administratively separate health wards (Mhala and Mapulaneng) each of which falls

under a different homeland administration (Gazankulu and Lebowa respectively). The Hoedspruit farming area falls under the jurisdiction of the Transvaal Provincial Administration.

This fragmentation has negative consequences for the organisation of health services. In the first instance, there are two loci of health authority at each district hospital; their activities are organised in such a way that each is completely independent of the other. This structured, non-co-ordination is exacerbated by the fact that each district health authority is accountable to a different regional head office situated a considerable distance away (Giyani and Lebowakgomo). There is little incentive for these offices to work together; this leads to on-the-ground anomalies that seriously undermine rational health service planning and implementation. Similarly, the Hoedspruit municipality plans and provides health services without taking into account the adjacent homeland health services.

Some results of this fragmentation include: (*i*) distorted patient referral patterns that result in patients having to travel long distances to reach 'their' hospital; (*ii*) associated increased travel costs to patients and families; (*iii*) extra cost to the health service which has to provide duplicate services in areas adjacent to each other; (*iv*) failure to ensure that local health care development, such as the siting of clinics, is according to population distribution; (*v*) inability of local services to provide ambulatory care properly (in cases of, for example tuberculosis or sexually transmitted disease); and (*iv*) failure to combine duplicate community services, such as school health, psychiatric or ambulance services.

This disorganisation, characteristic of the rural Transvaal, is described here to highlight some consequences of health service fragmentation, and underline the detailed understanding required *in each locality* if meaningful reorganisation of local rural health services is to occur.[8]

District health system development

The classic issues

The WHO's Division of Strengthening Health Services has produced a useful categorisation to assist with the systematic development of district health systems in support of primary health care.[2] Five areas are highlighted:

Organisation, planning and management covers important issues like the decentralisation of management authority and responsibility, and the facilitating of health service accountability to local communities. South Africa will need deliberately to strengthen its managerial capacity, particularly among senior district level staff with line responsibility. This subsection also stresses the need for population-based health information to direct personnel and finance to areas of major need. Such systems have to date played little role in local health service development.

Financing and resource allocation capability is necessary at local district level as at national and regional levels.

Development of human resources refers to the education and training programmes offered to district-level personnel. A special concern is continuing educational and logistical support for those located in the periphery of the district. Their needs, while usually acknowledged, are seldom a major part of activities at local level.

Community involvement refers to the role of local communities in the delivery of health services, the accountability of the services and the overall development of health systems.

Intersectoral action (along with community involvement) is a pillar of primary health care practice. The association of individual and community health status with determinants such as education, sanitation, food and shelter underlines the close relationship between community health and social development.[11]

District health system development in the rural Transvaal

In September 1992 a meeting was convened to launch a demonstration rural district health system effort in Bushbuckridge. Among the participants were representatives of local health services for the Mhala, Mapulaneng and Hoedspruit areas and leading members of the Gazankulu and Lebowa departments of health, as well as senior participants from the Department of National Health and Population Development. Such participation by responsible officers of these services is crucial to meaningful and informed change in the organisation of local health services.

The Bushbuckridge area was proposed as a case-study; technical discussions addressed the following key areas: (*i*) district management; (*ii*) education and local support; (*iii*) intersectoral approaches; (*iv*) health and management information systems; (*v*) community structures at district level.

The two-day meeting helped crystallise several issues central to district health system development. The issues are interrelated, yet each requires concerted attention if such development is to occur.

Key issues and concerns

Organising the district

The political/administrative divisions of the Bushbuckridge area and their consequences are noted above. Within the area, there is an emerging consensus among key community and health service groups that the first priority is to bring administrative coherence to the area as a *single* subregion with a uniform set of interests.

Thereafter, it is anticipated that boundaries for at least two *functional* health districts can be established each of which, given the presence of three local hospitals, will very likely include a sizeable 'community' hospital. These district boundaries are 'functional' and, as such, define the catchment population for which a particular health service is responsible. While each functional district will, in the Bushbuckridge case, include a local hospital, this is not a requirement for the demarcation of districts. It is vital that local communities participate directly in such district definition and that it is not imposed by government authority alone. The population size of these 'functional' districts will be limited to the 50 000 - 300 000 advised by some authorities.[8]

Management issues

District level management is the responsibility of senior health managers of rural hospitals, in this instance Tintswalo and Mapulaneng Hospitals. Hospital superintendents have responsibilities which involve all health facilities (hospitals, health centres, clinics, health posts, etc.) and community programmes in the health ward. This hospicentric managerial locus reflects the origins of health ward development, the curative preeminence of these services, and a failure to apply basic management principles to health ward functioning.

Such organisation can provoke serious shortcomings for the following reasons: (*i*) the substantial managerial

demands of administering 200 - 300-bed institutions, both with regard to expertise and time; (*ii*) the lack of management training and expertise that is directed at community health services responsible for tens of thousands of people; (*iii*) the inability to reconcile the competing interests of community and hospital services, when resources for each are combined in a single 'global' budget which has historically favoured hospital services.

These arguments favour the creation of a district health office, appropriately staffed with professionals from a variety of disciplines, and with a sound managerial and administrative capacity. Furthermore, the office should have a jurisdiction that supersedes either community or hospital services. In other words, part of its responsibility is to reconcile the competing demands of the community and the hospital sector. The institution of such an office(s) to serve the whole Bushbuckridge area is crucial to the future organisation and management of the Bushbuckridge district health service.

The role of a district hospital remains central, albeit in a form that supports and encourages community-based services, and seeks a greater balance between curative and preventive/promotive/rehabilitative activities.[12]

Relating the district to the regional health authority. At present the district authority has little independence of action, and homeland head offices can exert excessive control over its activities. This situation has developed over many years, with the frustrating result that local health services are unable to act without sanction from a head office that lacks the capacity to provide an enabling environment for such action. The result is a devolution of responsibility to the health ward level, with little accompanying authority and very restricted financial autonomy.

Newell argues that the relationship of district to regional authority is even more important than its relationship with the local hospital, but that this relationship 'has to be one of encouragement and assistance . . . . The (regional authority) should have a resource capacity and a colleague-to-colleague, rather than a paternalistic, relationship with a district.'[13] Achievement of this goal will require adjustments at both district and regional health office level.

In general, decentralised *authority* needs to accompany already decentralised responsibilities and this should include a significant measure of financial decentralisation; the opportunity to make savings and shift expenditures according to local priorities should be allowed for.

Working relationships and accountability of staff. Working relations between health professionals have for decades been characterised by hierarchical relationships within the same discipline. This has created an ethos of 'vertical' accountability between professional disciplines (i.e. doctor accountable to doctor, nurse to nurse and so forth). Yet the requirements of district health system development require a loosening of such relationships, and a strengthening of the 'horizontal' accountability between different members of the district health team. This is essential if the team is to act relatively independently and with authority, and provide leadership to the various personnel active at district level.

Serious administrative dysfunction can result in the absence of such authority. For example a clinic of the Tintswalo health service, some 10 km from the hospital, has a patient load consistently greater than other clinics. Since clinic nurses also collect patient fees, the hospital superintendent allocated a clerk to assist with this task. Within 2 weeks, and without explanation, the clerk returned to Tintswalo. On investigation it transpired that the administrative department at head office had overruled the superindent's action on the grounds that 'no clerk should work at a clinic' (personal communication — A. Pugh). This obviously undermined the authority of the district's senior health officer, and demonstrates the need to rethink district and regional lines of authority.

The role of the community

Since Alma Ata, statements on community participation have become commonplace. Newell comments that 'a district health system cannot function properly (without) the comprehensive involvement of the community it serves'.[13]

A key question relates to the nature of organisational structure able to incorporate broad-based participation, representation with accountability to community, and effectiveness in decisions on district level functioning.

Current efforts at Bushbuckridge attempt to combine the homeland-supported Mhala and Mapulaneng health advisory groups, with an emerging, broad-based and non-partisan 'community forum'. In addition, there are pilot efforts to introduce village-level health committees. A detailed proposal from representatives of 20 village settlements proposes a tiered structure of village health committees with representatives forming several area health committees which could form the basis for a single district health authority.[14]

The proposal has been submitted to a district health system working group and senior management at Tintswalo Hospital. The responsibilities of the district authority (which involve major participation by local health service leaders) are detailed and embrace overall policy development, services co-ordination and fiscal responsibility for the health affairs of Bushbuckridge. To reinforce community confidence in such a process, it is necessary for local health service leadership carefully to consider and respond to the proposals.

The district health system as a part of local government

Health is but one element of district-level local government, and several authorities point to the need for district health boundaries to coincide with those of educational services, water development, agriculture, etc.[2,8,9] In South Africa, it is likely that all such district systems, to a greater or lesser degree, are affected by shortcomings similar to those that affect health care.

The call for public accountability on the part of government departments is increasingly voiced, and is referred to in the draft 'Bill of Rights' documents of both the African National Congress and the National Party government. This sentiment also informs a growing demand for decentralised, honest government, both in South Africa and in other countries. With community organisation and involvement in social issues becoming steadily more cohesive in Bushbuckridge, public service accountability is a major concern at local community meetings.

Moving the process forward

Central to the approach taken in Bushbuckridge is the effort to create and sustain a co-equal partnership between three core groups: local communities, local health services and educational and research institutions that are active locally. This partnership is necessary to balance potentially competing interests, and to ensure that key stakeholders are involved in planning from the outset. There is a major 'rhetorical gap' between the principles that supposedly underlie public sector ser-

vices, and reality. Shared accountability and respectful partnership are necessary to narrow this gap. Moreover, time and resources are necessary to ensure the active and informed participation of all partners, but especially that of local communities. The North-eastern Transvaal Health Worker and Community Education Project (NETHWORC) has been central to the evolution of this partnership.

Because of the promotion of the district concept, and statements of support for its appropriacy and necessity, a broad consensus is emerging among all three groups in favour of the district health approach. This consensus is the basis for the convening of a non-partisan joint planning body, with representatives from the Mhala, Mapulaneng and Hoedspruit local authorities, capable of tackling the difficult issues that post-apartheid district health systems entail. Given the plethora of different authorities and the divided interests that have resulted from years of fragmented administration, the establishment of such a body requires tact, sensitivity and perseverance, and has to contend with frequent setbacks.

At the same time a series of short- and medium-term activities have been initiated in Bushbuckridge to foster a sense of progress. Examples include an inter-hospital planning forum focused on community services, the clinic building programme, rationalisation of ambulance services, a functional district planning process at Tintswalo Hospital, and joint tackling of development priorities, particularly the water and nutrition crises.

Conclusions

The above are early steps in a necessary and time-consuming process. South Africa has little experience of district health systems, yet understanding of the approach and wise application thereof to our local circumstances is essential if we are serious about the creation of a comprehensive national health system with primary health care at its core. Local endeavours, such as those in Bushbuckridge, Durban and Khayelitsha, should be viewed in this light.[6,7,15]

All these efforts are based on the belief that regional and national policy-making will have little impact if not more fully informed by on-the-ground realities. There is thus a critical need for local reality and experience to play a far greater role in the evolution of national health policy.

The institution of a district health movement in South Africa will require examples from a range of social and geographical circumstances. These will need to be supported and nurtured at regional and national levels. Moreover, the country will need *functioning* examples of district health systems if it is to train the personnel needed to staff and manage such systems effectively.

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This article was prompted by the district health systems planning workshop held in the eastern Transvaal in late 1992. Significantly the workshop brought together local health service leadership and members of the local Bushbuckridge community with educational and research institutions active in the area. The views expressed here, however, are those of the authors. A copy of the workshop record is available from the HSDU.

REFERENCES

1. World Health Organisation, United Nations Children's Fund. *Primary Health Care.* (Report of the International Conference on Primary Health Care, Alma Ata, USSR, 6 - 12 September 1978). Geneva: World Health Organisation, 1978.
2. World Health Organisation. *The Challenge of Implementation. District Health Systems for Primary Health Care.* Geneva: World Health Organisation, 1988.
3. World Bank. Restructuring and managing health care systems. In: *Better Health in Africa.* World Bank, 1992 (in press).
4. Zwarenstein M, Barron P. *Managing Primary Health Care In South Africa at the District Level: the MRC/IUPHC Workshop.* Parowvallei: Health Systems Division of CERSA, Corporate Communication Division of MRC, Oct 1992.
5. NPPHCN/SAHSSO National Health Policy Conference. Policy statement: proposed organisational structures for the public sector health services. Johannesburg, Dec 1992.
6. Tollman SM, ed. Report on the workshop to establish a demonstration district health system in the Bushbuckridge area of the eastern Transvaal. Tintswalo Health Service, Health Services Development Unit (Wits), members of the Bushbuckridge community. Acornhoek, Tvl, Sept - Oct 1992.
7. Solarsh GC, Coovadia HM, Loening WEK, Jinabhai CC. Workshop report: strengthening maternal and child health services at the district level in the Durban functional region. Durban, Feb 1993.
8. Tarimo E. *Towards a Healthy District. Organising and Managing District Health Systems based on Primary Health Care.* Geneva: World Health Organisation, 1991.
9. Kendall F. *The Heart of the Nation. Regional and Community Government in the New South Africa.* Johannesburg: Amagi Books, 1991.
10. Schneider H, Mavrandonis J, Price M. *Review of Health Services in Kangwane and the South Eastern Transvaal.* Vol. 6: Evaluation of Kangwane Clinics. Johannesburg: Centre for Health Policy, 1991.
11. United Nations Development Programme. *Human Development Report 1990.* New York: Oxford University Press, 1990.
12. Dean M, ed. *The Role of Hospitals in Primary Health Care* (Report of a conference sponsored by the Aga Khan Foundation and the World Health Organisation). London: Mendham Bowen, 1981.
13. Newell K. The way ahead for district health systems. *World Health Forum* 1989; **10:** 80-87.
14. District Health Constitution. A proposal for discussion from the Health Committee Working Group of the Community Forum. Community Practice Project, Agincourt, 1992.
15. Barron PM, Fisher SA. A district health service in Khayelitsha: panacea or pipedream? *S Afr Med J* 1993; **83:** 569-572 (this issue).