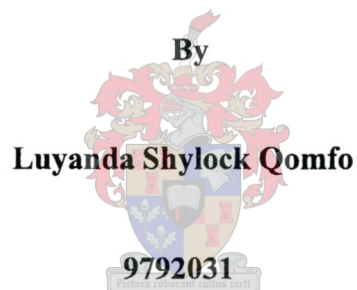An Assessment of the Feasibility of Implementing a District Health System in the City of Cape Town.

Research Assignment Presented in Partial Fulfilment of the Requirements for the Degree of Master of Public Administration at the University of Stellenbosch.

By

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March 2001

DECLARATION

I, the undersigned, hereby declare that the work contained in this study project is my own original work and that I have not previously in its entirely or in part submitted it at any university for a degree.

OPSOMMING

Die Suid-afrikaanse regering van nasionale-eenheid het met die aanvaarding van die Herekonstruksie en Ontwikkelings program (Hop) in 1994, Suid Afrika tot die ontwikkeling van gesondheidsdistrik stelstel verbind. Hierdie stelsel is gebaseer op die primere gesondheidsorg (PGS) benadering wat te Alma Alta in 1978 geformuleer is. Die PGS is die dryfkrag agter die verandering van verskeie gesondheidstelsels die wereld oor. Vanuit hierdie PGS het die distriksgesondheidstelsel ontwikkel. Hierdie distriksgesondheidstelsel word tans suksesvol in baie lande toegepas en is aanpasbaar by verskillende omstandighede, van die Afrika kontinent tot meer gesofistikeerd stelsels op ander kontinente.

'n Nasionale gesondheidstelsel gebaseer op hierdie benadering is ewe besorg om mense gesond te hou asook om na hulle om te sien wanneer hulle ongesond is. Die begrippe van besorgheid en welsyn word effektief en doeltreffend bevorder deur die skepping van n gedesentraliseerde omvattende bestuurseenheid van die gesondheidstelsel wat aangepas is vir plaaslike behoeftebevrediging. Hierdie eenhede voorsien die raamwerk vir n eie distriksgebaseerde gesondheidstelsel, waarbinne die distriksgesondheidsregeerders verantwoordelikheid vir die gesondheid van die totale bevolking en hul gebied aanvaar. Hierdie bevolkingsgebaseerde model laat toe vir voortdurende beoordeling en monitering van gesondheidsprobleme binne die distrik. Dit bepaal watter beskikbare fasiliteite en dienste voorsien moet word sodat doeltreffende en rasionele beplanning kan geskied.

Navorsing is onderneem om die lewensvatbaarheid van die implementering van n distrikgesondheidstelsal binne die stad Kaapstad, met 'n speciale fokus op finansiele en menslike hulpbronne, te bepaal. Die navorser het gebruik gemaak van 'n gestruktureerde vraelys en literatuurstudie om die lewensvatbaarheid tydens die implementering van die distrikgesondheidstelsel vir die stad Kaapstad te bepaal. Die belangrikste gevolgtrekking met betrekking tot hierdie navorsing is dat die stad Kaapstad oor die vermoe beskik om 'n distrikgesondheidstelsel te implementeer en te onderhou ten einde die lewenskwaliteit van mense te verseker. Daar is verder bevind dat daar genoeg personeel is om hierdie proses te voltooi. Die belangrikste aanbeveling sluit in die opleiding van personeel, die

bevordering van kommunikasie en deursigtigheid in verhouding tot finansies en voortdurende ondersteuning vanaf provinsiale en nasionale gesondheids departmente.

SUMMARY

The South African Government of National Unity, through its adoption of the Reconstruction and Development Programme (RDP) in 1994, committed itself to the development of a District Health System (DHS) based on the Primary Health Care (PHC) approach as enunciated at Alma Ata in 1978. This approach is the philosophy, on the basis of which many health systems around the world have been reformed, and out of which has developed the concept of the DHS. District-based health systems are now applied successfully in many countries, and have been adapted to a wide variety of situations, from developing countries on our own continent, to more sophisticated systems elsewhere.

A National Health System based on this approach is as concerned with keeping people healthy as it is with caring for them when they become unwell. The concepts of "caring" and "wellness" are promoted most effectively and efficiently by creating decentralised comprehensive management units of the health system, adapted to cater for local needs. These units will provide the framework for our district-based health system, in which a district health authority can take responsibility for the health of the total population in its area. This population-based model allows for constant assessment and monitoring of health problems in the district, the facilities and system provided, and leads to efficient and rational planning.

The researcher conducted interviews with key stakeholders, used structured questionnaires and observation and reviewed the relevant National and Provincial documentation and performed a literature review, to assess the feasibility of implementing DHS in the City of Cape Town.

The main findings of this research are that the City of Cape Town does have the capacity to implement and sustain the DHS, that it is necessary to implement the DHS in the CCT in order to improve the quality of life of the population, and that there is enough personnel to take the process forward.

The main recommendations include the need for training of staff, the promotion of communication and transparency in relation to finances and an ongoing support system from the provincial and national health departments.

The research assignment has revealed that the move towards DHS has the blessings of the top management and politicians of the CCT. In addition, it has been established that the CCT possesses good infrastructure, technical skills, and human resource capacity. There is also willingness on the part of the unions to take this process forward.

There are also challenges that need to be addressed, such as difficulties around staff attitudes, and the training of officials so as to accommodate the requirements of a comprehensive primary health care system, effective and efficient utilisation of available resources and change management.

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Firstly I want to thank my Lord Jesus Christ and my ancestors, for granting me the strength, wisdom and courage to complete this work successfully.

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1.   BACKGROUND TO THE STUDY

1.1   OVERVIEW

In 1994 the South African Government of National Unity adopted a district health system (DHS) based on the primary health care (PHC) approach as enunciated at Alma Ata in 1978 (South African Health Review, 1995:185).

The aims of the DHS are to overcome fragmentation; provide effective comprehensive health systems; promote and sustain equity of service provision; ensure the highest possible quality of service provision; ensure that district health services are planned, managed and delivered in a comprehensive, integrated manner; improve access to the health system; promote a developmental and intersectoral approach; promote sustainability; promote decentralization on health; enhance co-operation between public and private health providers and promote a community orientated developmental approach. (White Paper for the Transformation of the Health System in South Africa, 1997: 14-16).

The City of Cape Town (CCT) with all other municipalities in the Metropolitan Area is jointly conducting meetings with the aim of developing a district health system (DHS). The DHS has received broad support from the national, provincial, and local public providers; employee and employer organisations; private providers; professional associations and the health insurance industry (Gilson *et al,* 1997: 3). The CCT is a member of the Bi-Ministerial Task Team. This suggests that the CCT with other Metropolitan substructures is serious and committed to developing a DHS in the Metropolitan area.

In the CCT newsletter known as the "Commitment to Cape Town" (September, 1998: 2-8), there is a list of the CCT's strategic priorities. The researcher is of the opinion that these strategic priorities are in support of the implementation of a DHS. They include the following:

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- To ensure that the CCT is integrated and shares one vision,
- To promote an equitable distribution of system resources,
- To eradicate poverty and
- To promote a healthy, safe and clean environment.

The strategic priorities adopted by the CCT and its involvement in district health service delivery gives an indication that the CCT realises the importance of the principles of DHS development.

One of the difficulties in implementing the DHS within the Western Cape Province is the issue of governance (South African Health Review, 1996: 190). According to an interview with the Deputy Director on Policy making, PAWC, Dr. Blecher, on 6 August 1997 a committee known as the Bi-Ministerial Task Team (BMTT) was established by the former Minister of Health in the Western Cape (WC), Ebrahim Rasool. Its area of focus was to investigate the future governance of all primary health services in the WC. This committee was comprised of 60 task team members. They included trade union representatives and senior representatives from Provincial and Local government. Subsequent to its establishment, technical sub-teams on finance and personnel were also established.

The researcher has observed that although the process of amalgamation has been implemented in the various local authorities, the integration of the conditions of services is not yet in place. The debate about which conditions of services are going to be used within the Western Cape Local Authorities in particular came after the 1996 local government elections. These local elections resulted in the amalgamation of various local authorities such as Tygerberg, Oostenberg, South Peninsula, Helderberg Central Substructure and others. It is impossible for one local authority to have different conditions of service and disparities regarding salaries. The researcher is of the opinion that a team such as the BMTT is necessary so as to ensure the proper governance of the WC, particularly when it comes to the health services of local authorities. The fact that the Provincial Administration of the Western Cape (PAWC) is also concurrently running

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primary health services with local authorities is an indication that health services are fragmented in the province. This situation illustrates that a comprehensive health care system is not yet in place.

As the result of the uncertainties in respect of governance, three options were explored and recommended by the BMTT. They are the following:

I.   Provincial Government option, i.e. the province is responsible for the whole district health system.

II. Local Government option, i.e. the local authority is responsible for all district health functions.

III. Statutory District Health Authority option, i.e. the province, through legislation, creates a district health authority for each district.

In analyzing these options a framework was discussed at the BMTT's meeting on governance held on 6 August 1997 (Dr. Blecher, Deputy Director on Policy in Health, PAWC). This framework had to take note of the following aspects:

- Whether the option taken will make it feasible to implement the key principles of primary health care (PHC), the Reconstruction and Development Program (RDP) and District Health Systems (DHS).

- How political aspects will be taken into consideration in determining the governance option.

- Whether the implementation of DHS will accommodate any socio-economic demands.

- What effects it will have on finances.

- What the effective institutional/organisational structure will look like.

- Personnel aspects.

It is the opinion of the researcher that the gap needs to be closed between the conceptualisation process on how things should look and the realities facing the South African health system. The researcher also believes that the option chosen should answer the following questions that are crucial in the transformation of health:

- Whether the option or phase facilitates the achievement of equity in resource allocation between districts or not.
- Whether the option increases or decreases access to health care.
- Whether the local authority is able to absorb the resources provided by province and manage these resources effectively and efficiently.
- Whether the option facilitates or inhibits the provision of a comprehensive and integrated service.
- Will services be fragmented and duplicated?
- Will the adoption of the option facilitate referrals or not?
- Will the option facilitate decentralisation of decision making management and community participation or not?
- Will intersectoral collaboration be enhanced?

For the purpose of this research assignment it is not crucial to go into depth on why the local government option was chosen as the best one. The CCT is a local government (LG) that should analyze and assess the relevance of the local government option in relation to its circumstances.

It is important to note that local government in South Africa is in a process of transition. This means that a range of legislation affecting local government is being formulated or amended. The introduction of the White Paper on Local Government has resulted in the

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formulation of six megacities – Cape Town being one of them. The Cape Town Unicity came into existence after the local government elections, held on December 5, 2000. It is an amalgamation of the existing municipal administrations in the Cape Metropolitan Area. This amalgamation means the end of the CMC and the councils governing Cape Town, South Peninsula, Blaauberg, Tygerberg, Oostenberg and Helderberg (The Unicity Commission Gazette, 2000).

The amalgamation of the above municipalities means that they now must fall under one organisational structure and have one budget. The new Unicity council will have to work towards establishing one set of conditions of service (this means the previous 26 different conditions of service will now come to an end). The party with highest number of representatives in council (presently the Democratic Alliance) has the strongest influence in ruling the Unicity.

Up to the time of writing this research assignment there are no major changes that have come to the attention of the researcher except the following key issues:

The Unicity commission has prioritized negotiation with IMATU and SAMWU to discuss the following issues:

- HR policies and procedures,
- New uniform conditions of service for new employees,
- Collective agreements,
- Designing a new total cost of remuneration approach for existing employees to facilitate consistency and fairness.

In a statement on the delivery of health services after the local government election the National Department of Health said that it would be inappropriate, at this time, to rush into the complex task of allocating health functions and powers to the various municipalities, as required by the Municipal Structures Act. It also stated that the new municipalities must prioritise the amalgamation of all municipal health services within

their new boundaries and continue to render these services with the current resources, with support from provinces (Engelbrecht, 2000).

1.2   AIM, STUDY OBJECTIVES AND INTENTIONS OF THE RESEARCH ASSIGNMENT

1.2.1   AIM

The aim of this research assignment is to assess the feasibility of implementing the district health system in the City of Cape Town with a special focus on human and financial resource aspects.

1.2.2   STUDY OBJECTIVES

According to Mouton (1996: 102) study objectives concern what one wishes to achieve in the research. The objectives of this research assignment are listed as follows:

- To describe the current state of the health system and its historical roots in the CCT area.
- To describe the DHS and the motivation for its implementation.
- To give a brief input about the current state of district developments in South Africa and the Western Cape, in particular the CCT.
- To describe the current financial and human resource situation in the health system.
- To describe what is required in a DHS and how financial and human resources would be utilized.
- To assess whether the national and provincial Departments of Health will provide any financial and human resource support in strengthening the capacity of a DHS.
- To describe what would be required to get there and what obstacles there would be to achieving a DHS.

- To make recommendations to the CCT on how to optimise the implementation of a DHS.

1.2.3 INTENTIONS

The intentions of this research assignment include the following:

- To consider ways in which disparities in health service delivery within the CCT can be eliminated.
- To suggest where fragmentation, confusion and a waste of money on health issues in the City of Cape Town could be eliminated.
- To contribute to the promotion of the maximum effective and efficient utilisation of the available health resources.
- To examine the possibilities for equitable comprehensive health services throughout the districts of the CCT.
- To look at ways in which everyone in the city can be given access to the district health system.
- To promote the idea of community participation and intersectoral collaboration at a district health level by involving all the stakeholders in the decision making process.

1.3 MOTIVATION

The CCT inherited a fragmented, ineffective and inefficient health system. This has led to perceived dissatisfaction among the employees and the clients (the community in general) when it comes to the delivery of health services within this local authority. The research assignment is conducted for the following reasons:

- So as to ascertain whether is the CCT capable of implementing a DHS within its boundaries.

- To see how the process of effective and efficient co ordination of health systems can be facilitated.
- To raise awareness about the need for equitable access to a district health system.
- To ensure that there is maximum involvement of the community in the management of the health system within their area.

According to a Policy document for the development of a DHS for South Africa (1995: 7) and (Gilson et al, 1997: 3), environmental health is an integral component of any health system. The DHS is a vehicle for promoting equity, community participation, accountability and intersectoral collaboration within the health system (White Paper on the Transformation of Health System, 1997). The researcher is keen to see officials working hand in hand with others not necessarily within the health sector, but in other sectors such as education and housing. According to a newsletter of the CCT (Commitment to Cape Town, September 1998: 2), up to now the council has been in the process of facilitating the integration between the different administrations (i.e. Ikapa Town Council, Pinelands, Cape Metropolitan Council, previous Cape Town council and Crossroads Municipality).

It is the intention of the researcher to argue that a mechanism should be built where the staff will be accountable to the communities they are serving. The services that are rendered should be of good quality and should accommodate local needs and resources. It is the opinion of the researcher that the absence of a DHS has led to an uncoordinated health service. In order to promote a cost effective health system, the following key issues need to be assessed:

- The maximum gain must be achieved at a lowest possible cost.
- It is crucial to establish a district health service that is sustainable and that has a secured financial base to allow for long-term planning.

1.4   PROBLEM STATEMENT AND HYPOTHESIS

It is important to note that the health sector is co-ordinated by different stakeholders within the CCT area without clear lines of communication among the health role players. As the result of poor integration and communication there are different conditions of service within one local authority, including different salary scales, benefits, hours of operation and others. The environmental health system is working in parallel with the personal health system. In other words, they are not operating collectively. This can be illustrated by the fact that for a long period there were different managers and the health sectors were using separate budgets. There is no formal inter-departmental structure in place to discuss health problems that are cross-boundary in nature such as the problem of poverty. In 1994 the Government of National Unity adopted the DHS approach through the implementation of the RDP, but up to date the DHS has not yet been implemented in the CCT, as compared to other parts of the country such as Mpumalanga. The CCT is currently centralized: all the powers of the CCT are vested at the Civic Centre. Management, budgeting, training, requisitioning and other tasks are all undertaken at the Civic Centre.

According to Brynand and Hanekom (1997: 20) and Leedy (1997: 94), a deductive hypothesis is the hypothesis that is derived from the logical reasoning from theories that have been explored. Based on the above argument the researcher is of the view that the hypothesis in this research assignment is deductive in nature. The hypothesis in this research assignment is stated as follows: The City of Cape Town does have the capacity to implement a DHS, even given current constraints and resource limitations.

1.5   METHODOLOGY

As a result of the multi-disciplinary nature of this research problem, a plurality of research methods will be explored. Primary and secondary data will be examined to provide qualitative results. Data will be drawn from interviews with key stakeholders as well as from the examination of official documents, scientific journals, textbooks, and

company reports. On the quantitative side, some use will be made of the analysis of available statistics relevant to the topic.

The study will thus be both qualitative and quantitative. The aim is to combine these data sources for mainly descriptive and comparative purposes, such as the contrast between facilities and staff resources in different areas.

The following specific techniques will be employed: a literature review, the administration of questionnaires, and interviews. The in-depth literature review will be concerned, first, with an analysis of the relevance of the Constitution of South Africa. Second, the files and other relevant documents of the City of Cape Town will be scrutinized for pertinent evidence. Third, the researcher will review some of the key national, provincial and local authority policy documents. Finally, consideration will be given to trends discussed in international literature on developments in district health systems.

Primary and secondary data will be collected to provide qualitative results. The researcher will be in direct contact with interviewees so as to gather in-depth information on the relevant issues. Questionnaires will be structured, and an attempt will be made to administer them to a population of 20 key informants. While this is a relatively small sample, it must be remembered that the number of stakeholders with the requisite knowledge and experience is not all that large. The main data of concern can only be obtained from stakeholders that have insight into the local health policy process, and who are influential in the decision-making process in the City of Cape Town. Such stakeholders include officials from the following institutions:

- Governmental organizations,

- Non-governmental organizations,

- Academic institutions,

- Trade Unions in the Health Sector.

There are two interconnected variables with which this study is concerned:

- Estimations of the feasibility of implementing a District Health System in the Cape Town area.
- The current inventory of resources likely to be available at present and in the near future for successful implementation according to feasibility studies.

1.5.1   PRIMARY DATA COLLECTION

My primary data will largely be collected from key informants. Interviews will be conducted with selected role players after appointments have been scheduled. The interviews will be conducted both telephonically and in person through questionnaires. The target group will be key policy makers and health managers in the Western Cape province. The Annexe contains the final list of persons who were interviewed.

1.5.2   SECONDARY DATA COLLECTION

Secondary data consists of those sources of information that have been collected by other researchers (Brynard and Hanekom, 1997: 28; Leedy, 1997: 101; and Reid, 1994: 34).

Reference will be made to Acts, White Papers and other policy documents that will provide the necessary context for the development of the research questions. The following legal documents are relevant for the purpose of this research assignment:

- Republic of South Africa, Skills development Act No. 97 of 1998;
- Republic of South Africa, Labour Relations Act No. 66 of 1995;
- Republic of South Africa, Basic Conditions of Employment Act, No. 75 of 1997;
- Republic of South Africa, Employment Equity Act, No. 55 of 1998;
- The White Paper on Local Government, 1998;
- The White Paper on the Transformation of Health, 1997;
- Local Government Transitional Act of 1993;
- The National Health Bill, 1996.;

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- The Health Act, No 63 of 1977.

The comparative literature review is based on a perusal of conference reports, research reports, scientific journals such as the South African Medical Journal, World Health Organization (WHO) publications, books, newspaper articles and training manuals.

In an attempt to pursue the historical part of the research assignment, a brief overview of national events relevant to the topic will be given. The methodology will be deductive in nature (Mouton, 1997: 169).

1.6 DELIMITATION OF THE STUDY

According to Leedy (1997: 59), the delimitation of a study such as this one is about what the researcher is *not* going to do. The researcher, through his contact with different Bi-Ministerial Task Team members within the Western Cape Province, has concluded that human and financial resources are the main issues that will determine the feasibility of a DHS in the CCT. (Interview with SAMWU Metro treasurer, Director of PAWC in the Cape Metropolitan Area and CCT Director of Health). This assumption has been made by the researcher and confirmed with the stakeholders mentioned above. This research assignment is focused only on inputs with regard to the City of Cape Town, and is not concerned with the district health policy developments in South Africa or the Western Cape in general. The exclusion of other resources is not intended to undermine their valuable contribution to organizational development, but the specific aspects singled out by the researcher are more relevant to the fulfillment of the intentions of this research assignment as noted in section 1.2.2 above.

2. HISTORICAL BACKGROUND OF THE SOUTH AFRICAN HEALTH SYSTEM

2.1   INTRODUCTION

This chapter of the research assignment will provide a brief historical background to the South African health system. This system has deep historical roots that have been characterized as fragmented, racially segregated, curative and with a hospital bias (De Beer, 1984: 9). Special focus will be given to the following issues:

- The colonial era;
- The National Health Service Commission (Gluckman report);
- The Apartheid era;
- The South African political economy;
- The Transition era;
- The Post election era;
- The recent achievements of the South African health department.

This emphasis will provide a better understanding of the current state of the health service and its historical roots in the city of Cape Town.

2.2   THE COLONIAL ERA

The South African health system has been fragmented since the colonial era (De Beer, 1988: 69). The history of the South African health system began during the era of colonization where the southern tip of Africa was used to establish a refreshment station in the Cape in order to meet the health care needs of ship passengers (Owen, 1987: 69). According to Van Rensburg (1992: 36) the history of health started in 1652. This does not mean that there were no people in South Africa before 1652. It means that prior to 1652 the South African health system was not documented in detail.

The only information that is recorded is that the indigenous people were using their own traditional medicines (Van Rensburg et al, 1992: 36).

Right from the inception of the colonial process it is said that European settlers were sceptical of the indigenous health care system and that they tended to ignore traditional medicine. The tension over the differing approaches to medicine shows that there were irreconcilable cultural differences and intolerance between the indigenous and the European people. This is further illustrated by the rationale behind building a hospital such as Grey Hospital (De Beer 1984). According to Searle (1965: 35), the first private practitioner in South Africa was Jan Vetteman who was given permission to practice in 1654. This shows that private practice has been in existence for quite some time. The first small pox epidemic of 1713 and the second one in 1755 had high mortality rates, which prompted the establishment of two large hospitals. The decision-makers were thus showed a curative and hospital bias (curing diseases) rather than emphasising preventative means.

According to the South African Health Review (1995: 53), different groups of South African patients received different treatment for the same conditions in hospitals. For example, the treatment of venereal disease differed for soldiers, slaves, Khoi, Europeans and other free women. If a Khoi was infected, he or she was confined to the slave lodge until they received the treatment for the disease and were cured; they were also banished from going beyond Salt River. A slave would have to be cured at her or his own cost and would be given corporal punishment. Europeans and free women would be cured at their own expense and would be given bread and water for ten days by the government. This shows that the people were treated based on their colour.

In 1807 the first legislation on health was passed in South Africa and in 1858 the first medical school in South Africa was established in the Eastern Cape at Grey Hospital (South African Health Review, 1995: 61). The first hospital to be built was Van Riebeeck Hospital in Cape Town, showing that the Western Cape has long been a forerunner in health developments. A matron and a female slave were appointed as nursing aides (Van

Rensburg et al 1992: 38). By the end of 18th century the rich Cape burghers sent their children to Europe to train as doctors in order to return to the Cape to practise. This shows that only a certain class of people was able to practise medicine, and there were insufficient education facilities in South Africa in that period.

Different health professions started to emerge by the end of 1790 such as apothecaries, poccagemeesters (someone who attended patients with venereal diseases), food controllers, bookkeepers, cooks and others.

As the years went by, diseases such as typhus, smallpox, leprosy and others started to emerge. In 1755, nine hundred and sixty three whites and more than a thousand slaves died as a result of smallpox. This resulted in the establishment of two emergency hospitals – one for whites and the other for non-whites, in order to deal with the crisis (De Beer, 1984: 17). It is also surprising to realise that the life expectancy of Cape Citizens was between the ages of 40 and 50, with exceptional cases of people reaching 60 (Van Rensburg, et al, 1992: 39-40).

As a result of malpractice in the health field, a supreme medical committee was instituted in 1807 to issue certificates for the approved practitioners and to publicise the list of those approved. Several acts were promulgated in this regard, but it is surprising that even in 1830 there was no convincing evidence of the eradication of malpractice (Burrows, 1958: 72). It is only in 1908 that we see the first black professional nurse in South Africa. For more than a century in the history of South African health, there were no black professional nurses. This shows that there was no upskilling mechanism in place, and the dependency syndrome was promoted (Van Rensburg et al, 1992: 46). Somerset Hospital became the first civilian hospital to be built in 1818. The realisation of the need to build a hospital for civilians came late (after a hundred and sixty five years), compared with the early existence of hospitals for military personnel (Burrows, 1958: 107).

In 1856 Grey Hospital was built in King William's Town. This was the very first hospital to be built for the "blacks". The motive for this came from Sir George Grey who had the intention of winning black people to Christianity, promoting acceptance of the British Empire and ending the hold of witch doctors over black people (De Beer, 1984: 17). It was not anything new to see different levels of care, such as separate wards and administration for blacks and whites.

According to Van Rensburg, et al (1992: 47) Sir George Grey made special reference to Sister Henrietta Stockdale's report in 1876 where she reported on the conditions of hospitals "and made special reference to the Kaffir Hospital and the Kaffir ward". The official use of these words gives no doubt that discrimination on the basis of race was sanctioned long ago.

There were a number of cases of this nature that were encountered, which demonstrated the gap between the treatment of whites and non-whites:

> "*Eighteen men are put into a room which would scarcely hold six conveniently. They have very narrow beds, with only one thin mattress. There are no quilts, no lockers (unless a few boxes can be so called) no screens, no pictures, no books, except a few old volumes, which are kept in the pantry; neither a table nor a chair. There is no mortuary, the dead are put out under the veranda, in the veldt (for there is no enclosure), until they can be buried. The floor is the bare earth. There are never less than six urgent cases, waiting for a vacant bed.*"(Van Rensburg 1992)

This reveals that there was less care for the non-whites and there were unhygienic conditions.

According to Burrows (1958: 306), Robben Island was used as an institution for the mentally ill. Jails were constructed before hospitals, and the lunatics and lepers were isolated. Small pox was a leading epidemic. It is reported that in 1831 a mortality rate of

between 80% and 90% was experienced among the Griqua population. In summary, the colonial era was symbolised by racial divisions of health care, with the suppliers of health care being almost exclusively white. Apartheid medicine, segregatory structural arrangements and white domination on all fronts were experienced in every corner of the South African health system (CHASA Journal of Comprehensive Health, 1995: 163). According to Van Rensburg et al (1992: 57), the 20th century has been characterised by the spreading and legitimization of both the dominance of medical profession in health issues and the introduction of modern Western medicine. The Loram Committee of 1928 reports clearly on the strong segregation on the basis of race and colour in South Africa, and confirms the structural features of segregation, such as the training of black doctors.

The health care system was primarily concentrated in urban areas where there was a high level of health expenditure (Mills, et al 1988). The outbreak of the influenza epidemic in 1918, which claimed one hundred and forty thousand lives, resulted in a fundamental health reorientation and reorganisation in the South Africa health system (De Haan, 1993: 1). It exposed the shortcomings within the South African health system, with the result that emphasis was placed on the role of the state in public health matters.

Before the Union of South Africa was formed in 1910, there were two Boer Republics and two independent Colonial Governments which each had their own health system. A major outbreak of Spanish flu in 1918 killed three hundred thousand people in Cape Town within a period of six weeks (5% of the entire South African population). This resulted in an outcry and a widespread feeling that the Department of Health was ineffective in dealing with the epidemic. The Spanish flu led the government to draft the Public Health Bill, which later became the Public Health Act on 24 June 1919. According to De Beer (1987: 69) the Act allocated government bodies different responsibilities. Provincial administrations were given the responsibility for general hospitals, while local authorities were responsible for sanitation and infectious diseases.

2.3   NATIONAL HEALTH SERVICE COMMISION OF 1942-1944

The National Health Service Commission (NHSC) resulted in the popular 1944 report, known as the Gluckman Report. This report was named after Henry Gluckman, who was appointed during the time of the Smuts government to facilitate a commission that was aimed at addressing fundamental issues in the South African health system (De Beer, 1984: 15). According to the report of the National Health Service Commission (1944: 4-5), the task of the commission was to inquire and advise concerning the provision of an organised National Health Service and to resolve the social tensions that were experienced between the period of 1930 and 1940. The report recommended that the state should subsidise the training of black medical personnel and the establishment of rural health units (South African Health Review, 1995: 62).

The National Party government rejected all of these progressive recommendations when it took over.

According to De Beer (1984: 18-19) the following shortcomings of the South African health system were highlighted by the Gluckman commission.

- A lack of co-ordination
- Shortage of systems such as health personnel and finance, particularly in black urban and rural areas;
- Problems with private practices that were more interested in wealth than health benefits;
- The problem of inappropriate emphasis and priorities.

The commission realised that there was more emphasis on curative and institutional care instead of preventative and promotive health care. The training of health professionals concentrated on curative and surgical procedures, ignoring environmental measures and health education on preventing diseases. According to Van Rensburg, et al (1992: 63), the

commission revealed that "the systems are not organised on a national basis; they are disjointed and haphazard, provincial and parochial".

Accordingly the Report of the National Health Service Commission (1944: 181-182) made a number of recommendations, that are still relevant to the South Africa's present health care system such as:

- A unified system in which the community health centers would form the nucleus.
- Comprehensive health care and an emphasis on prevention.
- It went further and proposed that military service should be converted to civil service after the Second World War.
- The formation of a separate ministry of health and the extension of the district surgeon system to rural areas.
- The establishment of a single, central health authority responsible for the co-ordination, planning and effective use of the health system.
- Free health care on the personal system, financed by a national health tax.
- A need to ensure that the health system is adaptable to local needs. This was to be achieved by building community health centers.
- A proposal was made to develop human resources by training a mix of health personnel with the inclusion of a number of health visitors.

De Beer (1985: 58-59) and Van Rensburg (1992: 62) made the following deductions from the Gluckman commission: The system should be planned in an effective and efficient manner so as to make the best use of other available resources. The system should be decentralised and properly co-ordinated, and in order to improve the quality of life for all, there should be an effective and efficient health care system. The recommendations and deductions made by the Gluckman commission show that the health system was not managed in a satisfactory manner.

According to the Report of the National Health System Commission (1944: 152) the commission promoted a comprehensive and integrated approach to health care. The

commission further argued that unless sectors such as nutrition, housing, health education and others were taken into consideration (as against the mere provision of more doctoring), local authorities would not reap the fruits of an improved quality of life.

After a year, Gluckman was appointed as the Minister of Health. Within a period of two years more than forty-four health centres were built. They concentrated on access to health for all South Africans irrespective of race, gender and creed. Despite these achievements the commission felt that the Smuts Government undermined its efforts. According to the South African Health Review (1995: 53), the commission was even more frustrated and disillusioned after 1948 when the National Party took over. The era of the National Party was characterised by the coalition of white farmers, white workers and the Afrikaner capitalists. According to the South African Health Review (1995: 61), "in February 1945 the Minister of Welfare and Demobilisation accepted the report's recommendations with the reservation that the government would work within the limits imposed by the Constitution. The implications were based on the fact that the administrative and functional fragmentation of the health system would continue" (Report of the National Health System Commission 1944). This quotation illustrates that the government was not willing to accept any changes if it was contrary to the status quo.

2.4   THE APARTHEID ERA

The researcher is of the opinion that this phase serves as a continuation of the colonialist era, which was biased towards the colonists, the whites and the wealthy.

(Van Rensburg et al, 1992: 64) is of the opinion that apartheid existed long before 1948. Looking back to the colonialist era, the following existed: separate authorities, separate wards and clinics, separate hospitals and consulting rooms for whites and non-whites. From 1948 onwards apartheid was declared an official policy. The country concentrated on military mobilisation so as to maintain white supremacy (Price et al, 1986: 159). In the

1970's Bantustans were established and the Bantu Health System was also introduced (The homeland system was established under the grand apartheid era).

De Haan et al (1993: 3) argues that the National Party (NP) government created 10 homelands for blacks. Transkei, Bophutatswana, Venda and Ciskei became fully independent in 1977; the remaining six qualified for self-governing status. The establishment of homelands resulted in the creation of 10 additional health departments, the nationalisation of the mission hospitals and their transfer to the homeland governments. In 1983 the tricameral parliament led to 'own affairs' departments of health for Whites, Coloureds and Indians – resulting in an even more fragmented system. Blacks were allowed to exercise their political rights in homelands but not in South Africa. The Regional Health Organisation for South Africa (RHOSA) was established in 1979 as an attempt to co-ordinate the activities and planning of health system in the bantustans. Before that, the Health Act No 63 of 1977 was established with the aim of co-ordinating all the fragments of health systems that existed in the country. The three-tier system of 1919 was endorsed. The 1977 Act excluded the homelands (Owen, 1988: 9).

A number of inhumane measures were instituted to curb and to prevent the influx of blacks into "white South Africa" (Van Rensburg et al, 1992: 65). This process included the introduction of pass laws, influx control, the encapsulation of black areas as part of the homelands, and forced resettlement. This made health care inaccessible to the rural poor, who were served by inadequate health structures.

Price (1986: 159) categorised the homeland policy as the following, "the bantustans have functioned as dumping grounds for millions of people who were not needed by the white economy. Thus large numbers of unemployed, aged and sick Africans as well as children and those raising them, have been removed from 'white' areas. The social costs of supporting all these economically surplus people are thus exported to the bantustan.

The homeland areas were characterised as entities full of problems such as unemployment, poverty, overpopulation, illiteracy, squatting, inadequate sanitation,

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overcrowding, famine and housing shortages. These problems were accompanied by social ills such as alcoholism, promiscuity, crime and violence. Migrant labour resulted in the social disorganisation of families, thereby disturbing the culture and the norms of the society (De Beer, 1984: 43-50).

The formation of the homelands resulted in a high morbidity rate. Diseases conditions such as typhoid, cholera, kwashiorkor, gastro-enteritis and others were rife. An example of the major gap in the quality of life can be seen in the Transkei, which had 489 notifiable cases of TB per 100 000 people compared with the South African average of 256 per 100 000 (Van Rensburg et al, 1992: 66-67). Inequities existed also in the distribution of personnel, finances and other resources. A further example was the distribution of doctors in 1962, where only 232 doctors were allocated to the homelands, of a total of 8 248 for the entire country. As the years progressed the situation seemed to be deteriorating more and more. It is stated that only 3% of the Doctors were deployed to the homeland areas. These disparities are also highlighted in the form of capital health care expenditure, where a figure of R127 was budgeted for Cape Province and R16 in Lebowa per capita expenditure (De Beer, 1984: 59; and Van Rensburg, 1992:67).

According to De Beer (1984: 52-62) the homeland system led to conflict, hunger, confusion, fragmentation and a waste of money, as well as other social problems. This is why Savage (1979: 144) equates apartheid with illness. In fact he goes so far as to say that apartheid and health are irreconcilable.

Subsequent to the homeland system a number of commissions were instituted in South Africa, such as a Province Commission of 1980 that made its final report in 1986. This commission was established to rationalise the health system and to promote more effective and efficient service through the appropriate use of funds.

Prior to this, the 1972 Browne Commission did not bring any new changes that differed from the Gluckman commission. In support of the above information Van Rensburg et al (1992: 75) had this to say:

1. There was an excessive fragmentation of control over the health service and a lack of central policy direction.

2. As a result of the policy direction it was revealed that there was an under-emphasis on preventive and primary health care, and an overemphasis on expensive secondary and tertiary health systems.

3. Malpractice was experienced in areas such as medical schemes, tariff structures and others.

4. Disparities in the distribution of personnel in non-white areas and the curative bias were the norm.

5. The health information system was inadequate.

2. 5   POLITICAL ECONOMY

The South African economy was also affected by international recession as a result of the oil crisis and foreign exchange restrictions, which reduced investments into the country.

The economy of this country at that time was characterised by lack of competition, a high need for skilled labour, increasing unemployment and a balance of payments deficit. These structural constraints of apartheid were inherent in the social, political and economic policy.

In 1983, a tri-cameral constitution was adopted. The three houses were: The House of Assembly (white), The House of Delegates (Asian) and The House of Representatives (Coloured). According to De Haan (1993), this resulted in 14 extravagant and fragmented health departments with their own ministries and bureaucracies and this was characterised by duplication, overlap and confusion in the process to identify areas of operation within these 14 departments.

In 1985 a new health plan was established, but by August 1986 there was no change in the health system. Instead this health plan intensified bureaucratic delays and racial and

ethnic fragmentation over utilisation of resources, leading to an inefficient system. The system neglected more than 60% of the South African population. In 1985 the government introduced the Regional System Councils Act. De Beer (1987: 71) argues that the Regional System Councils (RSC) were general affairs councils, and states that the nature of their service was obscure. The Provincial Administration was regarded as a top-down structure, and had no achievable vision. It was regarded as fragmented and confused (South African Health Review, 1995: 58).

2.6   TRANSITIONAL ERA

According to Price (1986: 465), it is evident that these fragments created high costs, inequitable distribution of resources for health care and a health risk along racial, geographical, and socio-economic lines. Resistance against the apartheid regime and its consequences has been ongoing. In 1940 organisations such as the ANC were fighting against racism. The then Secretary General of the African National Congress, Dr. Xuma, argued against racist practices which were prejudiced against people of colour and did not consider the skills and ability of individual health practitioners (South African Health Review 1995: 64).

According to a Report on the Maputo Conference (1990), in the 1980's organisations such as National Medical and Dental Association (NAMDA), National Progressive Primary Health Care Network (NPPHCN), and others started to challenge the inequalities, inefficiency and ineffectiveness of the South African Health system.

In 1990 a conference of all the progressive health organisations was held in Maputo. The conference was held to explore means of creating unity and ways to negotiate with the Government on key health issues, so as to create an effective health service in South Africa. As a follow up to the Maputo conference, all the progressive health structures established a Patriotic Front. Within this period the ANC was playing an active role in the formulation of the National Health Plan, which started in 1987.

The National Health Plan for South Africa (1994: 20) indicates that in 1992, inter-provincial desks were established in all the provinces to formulate and discuss health policy. The first discussion document was issued in 1992 and the second in 1993. The last document was accepted as a plan in March 1994 with the assistance of the World Health Organisation (WHO) and the United Nations International Children's Emergency Fund (UNICEF). The following areas were regarded as priorities in the ANC's Health Plan:

- A Primary Health Care Approach
- Community Participation
- Inter-sectoral Collaboration
- One comprehensive integrated national health system
- Maternal, Child and Woman's Health (MCWH)
- Accessibility of Health in rural areas
- Establishment of a National Health Authority (NHA), Provincial Health Authorities (PHA) and a District Health Authority (DHA).
- Protection of the Environment
- Human Resource Development
- National Health Insurance
- A National drug policy

The Patriotic Health Front organisation formed the National Health Forum, which agreed on several issues to be addressed in the South African health system. These included primary health care, affordable and accessible health, equitable care, inter-sectoral collaboration, a National Health Service (NHS), and Maternal, Child and Women's Health (MCWH). The ANC believed that implementation of PHC would require political will on the part of the government, as well as commitment from communities, the health and allied workers union, health service managers and other health sectors. It felt that government policies should sustain the PHC through the establishment of a co-ordinated comprehensive national health system.

2.7   POST 1994 ELECTION ERA

On the 27th of April 1994 the first democratic elections were held in South Africa. The government of National Unity (GNU) came into power with President Nelson Mandela as the leader. The main focus of the GNU was reconciliation and nation-building (De Haan, 1993: 2).

The Minister of Health in this new government was Dr Nkosazana Zuma. Various committees were established in this ministry to look into the different aspects of health, such as National Health Insurance, the integrated nutrition programme and others (South African Medical Journal, 1994: 817).

In 1995 a committee led by Dr. Shisana (the then Director General of Health) was appointed to report on the National Health Insurance System. A draft policy document on the National Health Insurance System was published in 1995.

In August 1994 an inter-provincial committee was established to develop a District Health Authority (DHS) for South Africa which would be flexible from one province to another. All these discussions and draft documents were published for public comments. All comments from the public were carefully evaluated and assessed for possible amendment of the bills.

On 16 April 1997 a Government Gazette (No. 1790) was published (White Paper on the Transformation of Health) which dealt with the transformation of the health system in South Africa. The policy objectives and principles of this unified health system are highlighted below. The health sector has a mission, goals and objectives, which include amongst others, the promotion and involvement of communities in the formulation of health policies. The researcher is of the opinion that the ideal development is the one that involves the community from the policy formulation stage to the decision making stage. Based on the above historical background there is no mention of community participation and involvement in the decision making process.

The health department should not be only clinically orientated but have a broad scope of responsibilities, i.e. focus on preventative, promotive and rehabilitative health (A report on the Maputo conference, 1990: 25). It should emphasise reaching the poor, the under-serviced, the aged, and women and children, as these groups are known to be vulnerable to diseases (Towards a National Health System Document, 1995: 4). The restructuring of the health sector should be spearheaded by the following key principles (White Paper for the Transformation of Health, 1997: 11-16):

- To unify the fragmented health system at levels into a comprehensive and integrated national health system.
- To promote equity, accessibility and utilisation of the health system.
- To extend the availability and ensure the appropriateness of the health system.
- To develop health promotion activities.
- To develop the human resources available to the health sector.
- To foster community participation across the health sector.
- To improve health sector planning and monitoring of health status and system.

The researcher is of the opinion that these principles serve as an indication of the willingness of the government to implement PHC goals.

2.8   RECENT ACHIEVEMENTS FOR THE DEPARTMENT OF HEALTH

Within a period of five years the government had managed to put in place a number of significant guiding documents. To name but a few:

I. The adoption of the Reconstruction and Development Programme (RDP) document which provided an integrated vision for meeting the basic needs of all South African citizens (Reconstruction and Development Programme, 1994: 14-15). The RDP aims to develop human resources, build the economy, and democratise the State's effective implementation of government policies to promote sustainable development.

II. The adoption of the new Constitution of South Africa 1996, which represents a commitment to social justice in public policies, democratic institutions of policy making and public accountability, and a market based economic system with a clear regulatory and public service delivery role for the state (Budget Review, 1997: 1).

The researcher is of the opinion that the government regards the above two policies as the key policies to be used in governing the country, without excluding others. In both of these documents crucial developmental factors are mentioned, dealing with how health policies in South Africa should be directed.

A good reflection of the government's commitment to the country's health transformation is documented in the White Paper on Health Transformation (1997). According to the South African Budget Review (1997: 1.3) an economic growth rate of 3 % has been maintained since 1994. This is ground for hope, because in order to achieve wellness one needs to have a source of income, to live in a well-ventilated and lit house, to have safe drinking water and other essentials. Since 1997, Primary health care has been free of charge at the point of delivery. In 1996 a total of one hundred and two clinics were built and there were plans to upgrade three hundred and twenty six and to build two hundred and seventy two new clinics in 1997 (Budget Review, 1997: 8.8). The Budget Review (1998: 6.28) confirms that since 1994, five hundred and four clinics have been built. The underprivileged are given priority in an attempt to redress the imbalances of the past – for example the issue of affirmative action and the redistribution of wealth (Equity Act 1998). Children under the age of six and pregnant women have been receiving free health care since 1994.

Campaigns such as immunisation against polio and measles, measures to combat HIV/AIDS and tuberculosis are in the pipeline. The Termination of Pregnancy Act was passed in 1997. This act allows women the right to decide if they want to terminate their pregnancy or not (Budget Review, 1997: 8).

Expenditure on health has increased by almost 45% since 1995, and was set to reach R24 billion in 1999 and R28,3 billion in 2001 (Budget speech 1999: 14-18).

According to an interview by the researcher with Dr H. Mohammed, who is the Epidemiologist in the City of Cape Town (20 March 1999), the following successes have been experienced in the South African health system:

♦ The health system has switched from institutionalised hospital care to PHC.

♦ Adoption of the PHC Approach as the basis for the DHS for South Africa.

♦ Fourteen departments have been amalgamated into one national health department and nine provincial departments, this shows that the goal of unifying the health system has been fulfilled.

♦ The government has improved access to health care, particularly in rural areas and small towns.

♦ An additional 5 million people are obtaining health care.

♦ 8,5% of GDP is spent on health. This is an indication of government's commitment to the South African health system (Towards a National Health Plan, 1995: 1).

♦ Since 1994, five hundred and sixty seven new clinics have been built and 106 mobile clinics purchased.

♦ The allocation of One Hundred Million Rand in 1998 to repair dilapidated hospitals, with Two Hundred Million Rand being allocated in 1999 and further annual increases planned.

♦ Improved distribution of drugs, equipment and personnel to clinics.

♦ Free health care for pregnant women and children under 6 years was introduced in 1994.

♦ In 1997, free health care was extended to all attending primary care facilities.

♦ Collaboration with Cuban, German and other foreign governments to employ doctors in rural areas.

♦ Implementation of community service for new doctors.

♦ Emphasis on activities promoting health care, especially heightening awareness of the dangers of smoking.

♦ Currently the Primary School Nutrition Programme is feeding approximately five million school children in 14 001 primary schools.

♦ Inter-sectoral government plans to the combat the HIV/AIDS epidemic have been launched.

♦ Since January 1997, achievements in reducing the backlog in assertive devices for the disabled include the provision of 4 275 wheelchairs.

♦ During 1997 alone, 25 440 cataract operations for sight restoration were performed.

♦ The government embarked upon mass immunisation campaigns against the major vaccine preventable diseases. In particular, campaigns have been initiated to fight measles, hepatitis B and polio. Measles has been virtually eradicated in South Africa. The number of measles infections dropped from 22 000 in 1992 to 684 in 1998. This mass campaign has covered about 80% of children in South Africa.

♦ In an effort to reduce maternal deaths, these have been made notifiable as of December 1997. An important intervention has been the termination of pregnancy service, which is now accessible to an increasing number of women.

♦ The development of an Essential Drugs List in line with World Health Organisation (WHO) policy. In November last year, three books were published listing drugs used at each level of care (primary, secondary and tertiary).

♦ According to the UNDP's Human Development report of 1998, SA's life expectancy has increased from 63,7 to 64,1 since 1994.

♦ Introduction of a system of "rational prescribing" whereby patients are assured that when they visit a clinic the basic medicines will be available.

The researcher is of the opinion that the above-mentioned list of successes by the government represented progress towards improved PHC.

2.9 CONCLUSION

This chapter has revealed the underlying reasons for the need for a DHS in the CCT. It has also shown the reasons for the disparities in the health system and the recent

achievements of South African health department. The next chapter will focus on the framework of DHS developments in South Africa.

A number of important events have been captured in this chapter, they range from the colonial era to the 1994 elections. The researcher has tried to evaluate the health system in South Africa, looking at areas such as the development of legislation, the formation of health priorities and the manner in which resources were distributed during the colonial era.

In this chapter the researcher has realised that issues such as the fragmentation of health service and disparities in levels of service have long been in existence. This is characterised by differences in the allocation of resources towards the treatment of patients, based on rural/urban and racial divisions.

The establishment of the National Health Service Commission has thrown some light onto the history of the South African health system. Various issues of concern were raised in this section such as the need to catch-up on backlogs, co-ordination, inconsistency in prioritisation, and the problematic emphasis on a curative system. It has also been revealed in this section that recommendations included areas such as the promotion of a comprehensive and integrated health system. The Gluckman commission shows that the problems within the South African health system go back a long way, and were sustained by selfish political intervention.

CHAPTER 3

FRAMEWORK OF THE DISTRICT HEALTH SYSTEM DEVELOPMENT IN SOUTH AFRICA

3.1   INTRODUCTION

In this chapter, the researcher will explore the theoretical perspective of decentralisation, in particular the various aspects of the DHS. The first session will deal with the concept of decentralisation and its benefits. The different health-related roles of the three tiers of government will also be investigated. It is important to link the health discussions with legal provisions that will have an impact on health. Lastly, the researcher will address critical areas that need to be considered in implementing a DHS.

There has been widespread research about the relevance of decentralisation as opposed to centralisation as far as governance is concerned. This concept has been widely discussed by both developing and developed countries. China and Brazil are examples of the countries that have practiced the idea of decentralization. Mills et al (1990: 46 & 81) Collins (2001) state that there are numerous countries that are practice the idea of health decentralization. Botswana ,Denmark, Ghana, India, Philippines, Spain, Sweden, Uganda, Zimbabwe, Nigeria, Pakistan and New Zealand are representatives of this option.

Bahl (1992) and Thomas (1991) are of the opinion that countries that are at war or threatened by civil unrest tend to be more centralized than those that are operating in a harmonious and democratic environment. Collins (2001) went further by stating that decentralization is advantageous for the following reasons:

- It facilitates the process of getting government closer to the people. In return, maximum participation is likely.
- It is likely to provide an outcome that is closest to the needs of the median voters.
- It will allow the political process to guarantee more efficient operation of local government.

- Decentralization will make government officials more accountable to the surrounding community for the quality of services they provide.
- It will also encourage willingness among the local community members to pay for public services, since their preferences will be honoured.
- It is faster and is more appropriate in handling administrative problems.
- It is capable of promoting the improvement of management and the delivery of health services.
- It has the potential of promoting productive activities in order to generate more employment opportunities at local levels.

Mills et al (1990:54) further raises a concern that the "decentralization of the health system could provoke serious administrative problems without improving its effectiveness." Collins (2001) agrees with this statement, he is of the opinion that if devolution is poorly formulated and implemented , it can have a negative impact on health sector development. However, he feels that advantage of decentralisation outweights the disadvantages when it comes to the health development.

Other benefits of decentralization:

- It has the potential to promote greater and more effective community involvement.
- It is capable of improving inter-sectoral collaboration.
- It is seen as a way to revitalise democracy.
- Decentralisation is seen as an essential means of supporting the successful implementation of primary health care services.

3.2   A DISTRICT HEALTH SYSTEM

A district health system aims to assist the people of South Africa to improve their quality of life. It promotes co-operation towards ensuring healthier lives, it concentrates not only on curative means but also on promotive, preventative and rehabilitative health care (A Policy for the Development of DHS, 1995). At district levels health managers should be

easily accessible to the communities they serve and they should be in a position to understand the problems and needs of their clients. Health managers are expected to work harmoniously with CBO's, NGO's, private health sectors, traditional healers and other stakeholders. According to Bindari-Hammad and Smith (1992: 66-68) the DHS is seen as a vehicle for implementing primary health care (PHC) as enunciated in the Alma Alta declaration (Kazakhstan) in 1978.

To appreciate and understand DHS, it is important to understand the aims and principles of PHC. These principles include the prevention of certain diseases and the promotion of health by using health education as the main pillar (Dennill, 1995: 9). The following elements of PHC give an insight into the nature of the work that needs to be pursued by a District Management Team (DMT). That is:

- Provision of health education;
- Provision of essential drugs;
- Immunization;
- Maternal and child care;
- Treatment of common diseases and injuries;
- Adequate supply of safe water and basic sanitation;
- Communicable disease control and;
- Promotion of proper nutrition and food supply.

The PHC approach argues that health cannot be separated from other environmental factors affecting the country such as social, economic, political, technological and cultural developments. According to the White Paper on the Transformation of Health System in South Africa (1997: 224), a health district is described as a geographic area that is small enough to allow maximum involvement of the community in meeting local health needs. It should also be large enough to effect economies of scale. A health district should have a specific population, a clearly geographic defined area and a variety of health care structures that aim to involve all the aspects of community life which impact on health (Gilson, et al 1997: 3). A health district is viewed as a mechanism for

government to decentralise the health function to smaller geographic and administrative entities that will be both effective and efficient. A health district is seen as a more or less self-contained segment of the national health system, based on PHC.

A district should comprise a well-defined population, living within a clearly defined geographic and administrative area, whether rural or urban. It also involves all individuals and institutions providing health care in the district, whether non-governmental, social security, private or traditional. DHS takes other health issues on board such as housing, water, sanitation, education, employment, income, the environment and individual lifestyles (Tarimo 1991: 4). As the results of the development of health districts, effective communication between all levels of health care and facilities such as hospitals, laboratory service and other diagnostic, logistic and support systems will be promoted. DHS includes self-care and all health care workers and facilities up to and including the hospital at the first level and the appropriate laboratory, other diagnostic and logistic support services. DHS 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 services.

After the first democratic elections in South Africa, the government gave its full commitment to the implementation of PHC (South African Medical Journal, 1994: 817). A direct result of this commitment was the restructuring of the health service. In December 1995, the South African Health Department released a discussion paper on the policy for the development of a DHS for the public to comment on. Provinces started to prepare themselves for the implementation of DHS, and in 1997, started to appoint their regional Directors, demarcate district boundaries and put in place district management teams.

Gilson, et al (1997: 3) state that in 1996 there were one hundred and fifty seven health districts established in South Africa. The department of health set out a target of one hundred and seventy health districts. These district boundaries should be in line with

local government boundaries and other recognised non-discriminatory boundaries. Therefore they should be built in a way that allows for change. Currently a total of one hundred and seventy four-health districts, and forty two-health regions have been established.

The residential areas within the Western Cape province will be allocated within the health districts as set out in the Provincial Health Plan for the Western Cape (1995: 20). The size of each district will vary from one province to another as the result of the uniqueness of the area (Towards a national health plan 1995). A proposal of 24-health districts for the Western Cape Province has been made (Provincial health plan for the Western Cape Province, 1995: 24).

The South African Medical Journal (1994: 817) and a policy document for the development of DHS (1995: 7), states that it is advisable to have large districts that will be financially and managerially capable of providing different systems – such as environmental health systems, first level hospital care and emergency systems. Community participation, equity and accountability should be co-ordinated in a meaningful manner. A full package of comprehensive health care will include prevention, promotion, curative and rehabilitative measures, and this is expected to exist in all health districts.

It is envisaged that the district health system will be easily accessible to the community, therefore it should be clearly structured to allow for community participation in decision-making processes. The restructuring and decentralisation mean that the process of community participation will be more easily achieved at all levels of the management system (Swanepoel 1992: 113-117). The researcher is of the opinion that the process of intersectoral collaboration (the process where all the vital role players in building health, individuals and communities are drawn up) will be easily achieved once the decentralisation of health is in place. Taking into consideration the above picture, the process of inter-sectoral collaboration will be easily addressed.

The Policy for the Development of a DHS for South Africa (1995: 4-6) and the White Paper for the Transformation of the Health System in South Africa (1995: 28) say that in an attempt to accomplish the goals of PHC, a set of principles has been agreed upon to facilitate the aims of DHS. These principles are:

- Emphasis on promotion and prevention
- Intersectoral action
- Community involvement
- Decentralization
- Integration of health program's
- Co-ordination of separate health activities
- Equity
- Accessibility

The White Paper on the Transformation of the Health System in South Africa (1997: 29-36) says a DHS is one of the means of transforming the health system in South Africa, for the following reasons:

- To establish a unitary health service in order to improve the health of the community and to facilitate easy access to the health system.
- To establish a single authority that will be responsible for the provision of all district health services in the area.
- It ensures the decentralisation of authority through geographically coherent and functional districts.
- It aims to establish a single health service and an accountable health management team for each and every district.
- Accountability will be promoted at all levels. For example, the health team in each district will be liable to a single authority within a provincial and national framework.
- Systems at all facilities will be integrated (curative, preventive, promotive and rehabilitative).

- It is envisaged that in the long-term the health district boundaries will be in line with local government boundaries.

- Each district health team will be under the control of one authority as an employer.

- The DHS aims at ensuring that there are no disparities in salaries and this will be achieved by phasing in all public sector health personnel, regardless of different employment authorities.

- A comprehensive health service and a district hospital should be provided at a district level.

- An upper body, known as the Provincial Health Authority, will be responsible for monitoring, evaluating and supporting the district health system.

- There will be improved co-ordination between the health services provided, such as those that are rendered by private concerns, NGO's, traditional practitioners and others.

3.3   THE KEY ASPECTS OF DHS

Janovsky (1988: 10-11), Makan, et al (1997) and the Provincial Health Plan of the Western Cape Province (1995) state that in order for the DHS to survive and become sustainable, the following 4 pillars need to be given serious consideration. The following issues need to be implemented in order to ensure that a district health system is not just a good theoretical framework but a practical tool towards the transformation of health.

3.3.1   ORGANISATION, PLANNING AND MANAGEMENT.

The first pillar concentrates on the re-arrangement of the organisation in order to enhance its effectiveness and efficiency. The structure and the managerial processes involved in establishing PHC are key concerns. In this process several administrative functions are taken into consideration, including the following:

- Key performance areas of staff
- Goals

- Programme planning
- Delegation of authority
- Health and management information
- Monitoring and evaluation
- Planning
- Staff allocation
- Provision of drugs
- Supplies and Transport.

Management plays a key role in outlining and planning the different functions to develop systems and procedures, in order to put in place a research programme that will ascertain operational problems, and to be in a position to monitor and evaluate different intervention strategies and their cost implications.

3.3.2   FINANCE AND RESOURCE ALLOCATIONS

This is also a component of the planning and management of an organisation. Emphasis is given to finance and resource allocation because district financing is one of the key issues in developing the DHS (Makan et al 1997). An innovative mechanism of resource allocation from the centre to achieve equity objectives without taking away from the base is both feasible and desirable in the process of DHS development. It is important to note that although much more financial independence for the tiers of management may be argued for, accountability is required and necessary. Health districts should play an innovative role in resource allocation decisions, identification of sources of financing and development of useful financial information systems (Janovsky report, 1988: 10).

3.3.3   INTERSECTORAL ACTION

Intersectoral collaboration is aimed at co-ordinating all the sectors that are contributing to health services. The concept of health is complex. It is the improvement of quality of life and it requires many participants, such as those involved in cleaning water, improving

sanitation and housing, supplying better food and trying to raise income and educational levels (Provincial Health plan of the Western Cape Province, 1995: 4).

3.3.4   COMMUNITY INVOLVEMENT

Swanepoel (1992: 107) states that the main objective of community involvement is empowerment, capacity building, awareness and mass mobilisation on health issues. Community involvement forms part of recognising human resources and the promotion of sustainable development. In 1995, a national committee suggested that Community Health Committees should be formed from community development forums or community health forums (South African Health Review, 1996: 191). The committee went further by proposing that district health clinics be formed with participation and representation from the community health committees that formed the governance structure in the districts. District health boards will also be formed, where representation from lower structures will govern the district hospitals. It is important to note that the functions, structure and memberships of these formations will be determined by provincial legislation (Draft Provincial Health Plan, 1992: 40-41). It is crucial to take note that this process requires broader consultation and it needs to be sustainable. The researcher is of the opinion that development without the optimum involvement of the community is a futile exercise.

3.4   THE ROLE OF GOVERNMENT IN HEALTH

The government is under obligation to provide a health system in South Africa (South African Constitution, 1996: 13). Provision is made in this regard that outlines different roles of government with its three-tier government (National, Provincial and Local government). As the result of the multi-dimensional nature of health care, breakdown of these roles will be made:

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3.4.1 NATIONAL GOVERNMENT'S ROLE IN THE HEALTH SYSTEM

Gilson et al (1997: 6) state that the National Department of Health is expected to play a significant role in ensuring that equity and efficiency are promoted at all levels of health service delivery. This can be done under the overall principle of decentralisation. Defined by Mills (1990: 15-16), decentralisation is the devolution of power to the lower levels of an organisation. It is hoped that this process will assist in boosting the morale of the staff, encouraging local initiative and flexibility in the light of local and changing circumstances and increase both accountability and efficiency. Section 27 of the South African Constitution (1996: 13) states that South African citizens have the right of access to the health care system, this means that the government has the role of ensuring that health services are in place to support the community.

The following key tasks need to be performed by the National Health Department (Towards a National health system, 1995: 7-10).

3.4.1.1. GENERATING AND DISSEMINATING POLICY ADVICE

There is a need for policy expertise and knowledge. These policies need to be generated and implemented in an appropriate manner. The advantages and disadvantages should be identified in an attempt to develop a well functioning DHS.

3.4.1.2. PROVIDING TARGETED TECHNICAL SUPPORT

It is the role of national government to give technical support to all provinces so as to help lower levels translate broader policy frameworks into detailed legislation and policy guidelines suited to each specific situation (South African Constitution, 1996: 143-144).

3.4.1.3. FACILITATION EXPERIENCE AND INFORMATION EXCHANGE

The program outlined in the White paper for the Transformation of Health in South Africa (1997: 18), needs to be set by national government to establish exchange programs across the provinces. The process of information exchange can be conducted in various forms, such as internship of health managers to other countries, and research and liaison with other international agencies. This will assist in sharing challenges and workable solutions to provide advice.

3.4.1.4. ADVOCACY CONCERNING DECENTRALISATION

This is expected of officials in the National Department who are tasked with decentralisation. They should play an advocacy role to ensure that the necessary powers are devolved to provinces and districts for the effective implementation of the DHS (Gilson et al 1997).

3.4.1.5. CO-ORDINATION OF POLICY ACTIVITIES

Information needs to be gathered concerning the implementation of policies by all the provinces. This information should be channelled towards the common objective of enhancing health districts. The national department will also be responsible for reviewing, defining, co-ordinating, integrating, synthesising and monitoring fundamental relationships within the national health system (White Paper for the Transformation of the Health System in South Africa, 1997: 18).

3.4.1.6. SUPPORTING AND MONITORING PROCESS

The national department in conjunction with provincial health departments should set up indicators, periodic benchmarks for evaluation and monitoring purposes. These efforts should assist in promoting integrated health and management information systems and

should be used as a basis for sharing experiences and challenges across the provinces, when it comes to service delivery.

3.5   THE ROLE OF PROVINCIAL HEALTH DEPARTMENTS

The Constitution of South Africa has made legal provisions concerning the delegation of powers to the provincial governments (South African Constitution, 1996: 60). These powers include the allocation of resources, as well as planning and developing a framework that will be used as a basis to promote equity and efficiency across the provinces. The provincial departments are also there to play an enabling role, similar to that of the national Department of Health, which gives technical support to provincial and local government (South African Constitution, 1996: 60-61 & 143-144).

The provincial health department is there to provide broad policy guidelines. The provincial health department should provide funding in respect of district health services. The Provincial Administration of the Western Cape (PAWC) and other provinces have the role of monitoring the quantity and quality of services rendered by local government (Provincial Health Plan of the Western Cape Province, 1995: 15-16). This role includes the provision of support in rendering of services, e.g. training standards of protocol development and others.

There are regional managers or directors that have been already employed by the provinces. These managers are there to assist in areas such as co-ordination of the development of the district system, co-ordination of all district and regional health systems in the region, the rationalisation and relocation of regional hospital systems, and to act as a communication bridge between the district and the province. Provincial health departments need to ensure that there will be formulation and implementation of provincial health policies, norms, standards and legislation (Provincial Health Plan of the Western Cape Province, 1995:17).

The White paper on the Transformation of Health (1997: 26-28), states that the Provincial Health Department should also serve the following functions:

- The provision of regional and specialised hospital services, as well as academic health systems, where relevant;

- Inter-provincial and inter-sectoral co-ordination and collaboration;

- Appropriate human resource management and development;

- Co-ordination of the funding and financial management (the budgetary process) of the district health system;

- The rendering and co-ordination of medical emergency systems (including ambulance services);

- The provision of technical and logistical support to health districts;

- The rendering of the medico-legal services;

- The provision of non-personal health services;

- The rendering of health services to those detained, arrested or charged;

- The screening of applications for licensing and the inspection of private health facilities;

- The rendering of specific provincial service programs, e.g. tuberculosis programs;

- Quality control of all health services and facilities;

- The planning and management of a provincial health information services;

- The provision of an occupational health services;

- Effective consultation on health matters at the community level;

- The provision and maintenance of equipment, vehicles and health care facilities;

- Research on, and the planning, co-ordination, monitoring and evaluation of the health services rendered in the province, and

- Ensuring that functions delegated by the national level are carried out.

The commitment by the provincial government to abide itself to the constitutional obligations and the provisions given by the White paper on health transformation is crucial. This intergovernmental relations will strengthen trust and communication between various spheres of government.

3.6 THE ROLE OF LOCAL HEALTH DEPARTMENTS

In relation to the provisions made by the South African Constitution (1996: 144), it is expected that local government will be the main point of municipal health service delivery. Local authorities or substructures will be divided into districts. Each district will be autonomous but within the guidelines of the local authority (South African Medical Journal, 1994: 817).

Each and every district will have a community health centre that will co-ordinate the health services within a defined population. It is expected that the community health committees will establish these committees, which will act as the mouthpiece of the community. They will ensure that there is maximum involvement and participation of the society in health and health service provision (A Policy Document for the Establishment of the District 1995).

It is the belief of the researcher that accountability will be promoted within the boundaries of health districts by creating clear lines of communication and clear responsibilities. Each district will be a running comprehensive health services whereby all health sectors will be accessible to the community (such as environmental health, obstetric services, emergency services and ambulance services) (Gilson et al, 1997: 5).

The Policy document for the Establishment of the District Health Services (1995: 59), states that the service that will be rendered at a district level will include the following:

1. Nutrition services
2. Oral health services
3. Family planning service
4. Appropriate occupational health services
5. Health monitoring services.

Inter or intrasectoral collaboration can be easily implemented at a local level, this idea need to be promoted not only within government circles but also among NGO's, the private sector and other stakeholders. Each district will have a district hospital that will also provide a comprehensive and integrated community health system as outlined above (Monekosso 1994:22). There will be a comprehensive structure known as the District Health Authority. The DHA will consist of the following representatives: community health committees, heads of district health units and the Director of the District Health System. According to the Reconstruction and Development Program (1994: 44-45), the DHA should have a number of functions that will include the following:

- Provision of appropriate personnel management and human resource development for district health personnel;
- Management of the district health budget;
- Maintenance of equipment, facilities and other assets;
- Promotion of PHC, support for, and planning, co-ordination, and evaluation of services based on national and provincial norms, policies and guidelines;
- They will also be responsible for ensuring that there is an efficient referral system within the district and between the district and provincial and national facilities, such as training institutions and hospitals.

In addition to the above-mentioned roles and functions, special emphasis will be placed by the governing body on the subsequent aspects. However, this depends on the outcome of negotiations between the province and the municipalities concerning their agreement on issues such as clarity on constitutional provisions and guarantees regarding the availability of resources (White Paper for the Transformation of the Health System in South Africa, 1997: 31):

- Provide funding in respect of the municipal health services;
- Manage the district health system within the framework of PAWC policy guidelines and relevant legislation;
- Formulate and execute operational policy;

- The district health services to be rendered will be determined through negotiations between local government and the PAWC, and governed through a performance contract;
- Ensuring health promotion services;
- Providing for appropriate human resource development;
- Ensuring the performance of any other health function or duty assigned to the health district;
- Ensuring the provision of the environmental health services; the promotion and maintenance of environmental hygiene; the prevention of water pollution; enforcement of environmental health legislation, i.e. regarding sanitation, housing, smoke, noise, litter, food hygiene and occupational hygiene; identification and control of local health hazards;
- Monitoring and evaluating health and health service provision;
- Ensuring the provision of support systems essential to the rendering of health services, including: accommodation for staff, appropriate facilities for the rendering of maternal and mental health systems; essential medicines; essential diagnostic systems; transport; and the maintenance of equipment, facilities and other assets;
- Ensuring the availability of a full range of PHC and other relevant health services in communities, clinics, community health centres, district hospitals and other facilities;
- Ensuring the promulgation of health by-laws;
- Gathering, analysing and managing health information at the district level.

The previous section identified the importance of good management, and the need for co-operation and effective communication. Kielmann, et al (1991:2) states that the role of government in district health service delivery is very complex in nature. It involves aspects such as, finances, human resources, legal concerns, and political and socio-cultural factors. The promotion of inter-dependence between various departments in government is crucial for sustainable health development, the researcher is in agrees with this view.

The following section will concentrate on some of the legal issues around the development of district health, related in particular to the Western Cape as reported by the Bi-Ministerial task team of the Western Cape.

3.7 LEGAL PROVISIONS RELATED TO HEALTH

This section of the research assignment will be dealing with the legal issues that have a bearing on health. Although there are a number of legal complexities related to health, only the key aspects will be dealt with, such as the legislative and constitutional framework, local government restructuring, the Transfer of Municipalities Staff Act and the Labour Relations Act.

3.7.1 LEGISLATIVE AND CONSTITUTIONAL FRAMEWORK

The Bi-Ministerial Task Team has reviewed the legislative and constitutional framework governing the provision of PHC. A number of legislative provisions will be taken into account in determining the authority responsible for PHC. The National Health Bill, which is to be published within a year, makes provision for the establishment of health districts (Blecher 1997). It will give substantial impetus to this process, because the role of government institutions will be clearly defined in all PHC-level systems in a geographically defined area. These systems should integrate preventive, promotive, curative and rehabilitative aspects, run by a single authority in charge of the district health system.

The Constitution of South Africa (Act 108 of 1996) prescribes that local government has a right to deliver certain aspects of PHC, which it defines as a municipal health service. It establishes certain provisions for the determination of local government; its functioning, financial regimes and powers. It makes specific reference to both health service and municipal health systems. Health Service (Part A) and Municipal Health Service (Part B) are listed in Schedule 4 of the Constitution entitled Functional Areas of Concurrent National and Provincial Legislative Competence. Functions listed in Part B of Schedule 4

are uncontested local government responsibilities (in this case Air Pollution and the Municipal Health System). Systems other than the municipal health system may also be devolved from provinces to local government.

Section156 (4) says:

"The national government and provincial government 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, if

- *The matter can be more effectively administered locally; and*
- *The municipality has the capacity to administer it."*

The Constitution does not define the municipal health services. It is quite likely that municipal health services might be interpreted legally as those functions which were performed by local government at the time the constitution was promulgated, or alternatively in terms of the Health Act (63 of 1977). Although these services historically focussed on preventive and promotive health, over time larger municipalities have to varying degrees extended the curative health care system they provide and can claim that these are included in the definition of municipal health systems. There are therefore varying definitions of Municipal Health Systems in different local authorities, depending on their size.

The constitutional provisions that have been discussed, such as schedule five and six, have effectively precluded the implementation of the provincial option of governance for the complete district health system package. It has become evident that, where local authorities have the administrative capacity to render the district health system, they do not agree with the provincial option as a means for governance (Report on governance 1997). In the Metropolitan Area (Six Western Cape substructures), the Local Government Transition Act (Second Amendment Act No 97of 1996) currently prescribes that:

"municipal health services are to be delivered by the Metropolitan Local Councils (MLCs), and the health services and staff of the Cape Metropolitan Council (CMC). These have already been transferred to the substructures on July 1, 1997". The CMC continues to retain certain co-ordinating and facilitating functions for a municipal health system, as well as providing certain metropolitan-wide pollution monitoring and control measures, and certain specialised health systems (Cape Metropolitan Council Newsletter on restructuring 1997).

The Health Act No 63 of 1977, which currently determines the responsibilities of the various authorities, will need to be amended in due course. Provinces can do this as the relevant sections have been assigned.

3.7.2   LOCAL GOVERNMENT RESTRUCTURING

According to the Initiative for Sub-district Support Newsletter (1991: 1), local government transformation is important in health service delivery for the following reasons:

- There is a trend which used to be followed by South African municipalities in terms of functioning. This means the local government is expected to play a key role in development initiatives.
- The changes will impact on the work of health officials.
- The local government will play a vital role in district health development within its jurisdiction.
- As the main source of service delivery, local government is in a better position to mobilise communities and to facilitate interaction between different role-players in the health sector.
- It promotes active community participation in the municipal decision-making process
- It promotes the use of integrated development planning in all the clusters of local government.

This process of transformation requires health personnel as well as the community to be familiar with developments in the local government. The researcher will provide short account of these developments.

The White Paper on Local Government was released in March 1998. The Local Government Municipal Demarcation Act was passed, the Local Government Municipal Structures Act No. 117 of 1998 was also passed but not yet implemented and the Local Government Municipal System Bill Notice 1776 of 1999 will be gazetted shortly. Local Government Boundaries will change for the final phase. One of the essential features of the DHS is the subdivision of the province into a manageable number of service of districts.

The development of the DHS would be greatly facilitated by the restructuring of local government into a more coherent and efficient system. Twenty five health districts in the Western Cape Province were defined and mapped in the Provincial Health Plan for the Western Cape (Health Systems Trust Update 1997: 10). However, health district boundaries in this province will only be finalised after the rulings of the Demarcation Board on new municipal boundaries and in consultation with local authorities. It is expected that this process will be finalised before the year 2000 local government elections.

3.7.3 TRANSFER OF MUNICIPALITIES STAFF ACT OF 1998

To have meaningful integration of a district health system, it is important to take cognisant of the legislation that plays a role in facilitating the process of integration. The researcher views the Transfer of Municipalities Staff Act as a milestone towards ensuring that this process is a success.

Legal opinion was obtained to determine whether the Transfer of Staff to Municipalities Act No. 17 of 1998 applies in this instance, and can form the principle Act on which the process of transferring personnel is to be based. According to Schedule 2 of the Transfer

of Staff to Municipalities Act (1998: 2), subject to the Labour Relations Act of 1995, the MEC for local government is actively involved in the process of transferring staff from the provincial administration to the municipalities. No employee may be transferred without his or her consent or without agreement of the designated municipality. Conditions of service may, on aggregate, not be less favourable than those applied before the transfer. Issues pertaining to transfer of vacation leave, pension fund arrangements and disciplinary or grievance procedures are covered in the Act. The legal opinion suggests that the Act is applicable, provided that the following criteria apply:

- The transfer must be necessary for the effective administration of the municipality in question.
- The transfer must enable the municipality to render systems effectively.
- The municipality must be designed by the MEC as a municipality to which employees may be transferred.
- The implication is that the transfer should not be due to a provincial rationalisation process.

3.7.4 LEGAL FRAMEWORK

A good relationship between the employer and employee is important for effective and efficient service delivery. The Labour Relations Act promotes the maximum use of internal resources in the case of disputes between the employer and the employee, and to promote employee participation in decision making through the establishment of workplace forums.

The Labour Relations Act has a bearing on the health transformation process in particular Section 197. This section deals with the transfer of contracts of employment. Any agreement reached by the parties (employer and employee) can be given legal effect through a proclamation (Labour Relations Act 1995: 199).

The Municipal Structures Act No.117 of 1998 has implications for the process of allocation or re-allocation, which also includes the assessment of the capacity of a local authority in rendering the system. This process will have an impact on the transfer of staff between municipalities as well as the final decision regarding the specific municipality that will render District Health Systems (Municipal Structures Act No.117 of 1998: 60).

With reference to the Employment Equity Act (No.55 of 1998), it is clear that the receiving local authority must comply with the Act, and in particular Section 20. This section requires that an employer must prepare and implement an employment equity plan.

As indicated, personnel and financial resources are the main factors to be given attention in this research assignment. The researcher is of the opinion that the Labour Relations Act and Employment Equity Act are among the legislation that plays a vital role in the process of allocation of personnel. The above-mentioned legislation needs to be considered carefully in the process of implementing DHS. The ignorance of these legislation may lead to low moral of staff and major conflict between the employers and the employees and delay the health service delivery. The following section will address the critical areas for implementation of DHS.

3.8 AREAS TO BE ADDRESSED IN IMPLEMENTING A DISTRICT HEALTH SYSTEM

3.8.1 BRIEF OVERVIEW

This part of the research assignment will be looking at responsibilities at the various spheres of South African government in implementing the DHS. Input will be given on brief legal provisions available in the country, and should give guidance on how the DHS should be developed. Focus will be on the following areas of implementation: personnel and training; organisational structure; the district health care team; delegation, supervision and incentives; supplies, logistics and maintenance and financial

management. The researcher is of the view that the above-mentioned implementation aspects are imperative in the development of a DHS.

The RDP (1994: 43-44), recommends that all stakeholders in health should be co-ordinated under the umbrella body of the national health system (NHS). A policy for the development of a DHS for South Africa (1995: 8) stresses the point that districts are not separate and completely autonomous units, but are part of an integral NHS.

National Health Plan (1994: 65-66) argues that there must be a single Minister of Health and a single National Health Authority (NHA). The NHA is expected to develop national policies, standards, norms and targets, allocate the health budget, co-ordinate the recruitment, training, distribution and conditions of service of health workers, develop and implement a national health information system.

SA has nine provinces, and it is expected that each province should have a Provincial Health Authority (PHA). These bodies will be responsible for providing support to all the district health authorities in each province (A Policy for the Development of a District Health System for South Africa, 1995: 8).

3.8.2   HUMAN RESOURCE DEVELOPMENT

Mechanisms need to be devised to ensure that staff members are adequately trained or re-orientated towards PHC. Tarimo (1991: 75) recommends that several training courses need to be conducted, such as refresher courses and specialist courses. This process of training should be planned in an integrated manner. The training plan should also indicate who needs to learn and how urgently the training is required (Amonoo-Lartson et al, 1984: 159-160). It is the opinion of the researcher that the training of personnel should be based on the needs of the area, which should also include the situational analysis of an area. The situational will help the health professionals to make informed decisions.

The researcher is of the opinion that newsletters, workshops and seminars need to be promoted in this process of mass mobilisation. A curriculum of training basically will depend on the needs of the community and staff of a particular district, but should not exclude PHC training package (Kielmann et al, 1991: 36-39). The health staff needs to be encouraged to organise re-orientation programs with community leaders, youth movements, trade unions, political organisations, women's organisations and other community stakeholders. Amonoo-Lartson (1984: 159-160), states that for the purpose of ensuring that the organisation becomes successful, it is important to realise that the training of personnel should not be treated as a misuse of resources. A training plan of an organisation should not only target the newcomers but also other levels of management in the organisation.

3.8.3   ORGANISATIONAL STRUCTURE

The researcher views the introduction of PHC in the South African health system as a form of transformation, hence it will require a change in structures and the way of doing work. Tarimo (1991: 81) is of the view that a district level health system can be administered independently in separate units or comprehensively in one unit. The South African health system must be based on an integrated and multidisciplinary approach that will promote effective and efficient service delivery (Reconstruction and Development Programme, 1994: 43). This means that preventative, promotive curative and rehabilitative health will be co-ordinated at a district level.

3.8.4   THE DISTRICT PRIMARY HEALTH CARE TEAM

A district health management team includes many stakeholders. The representatives on this team depend on the services that are available in a particular district. The following professionals should be included in the list: district health manager, hospital doctor, environmental health officer, public health nurse, hospital administration and a finance officer (District Health Manager, 1994: 57-58). It is possible that within the district, other teams might be involved, such as: Village Health Committees, District Hospital

Management Teams, District Hospital Advisory Board and District Health Management Teams (A Policy for the Development of a DHS, 1994: 27-30).

In order to prevent overlap and confusion, it is wise to define terms of references of these teams, which will ensure efficiency in the district. Motivation and orientation of health personnel around the PHC system will increase the effective utilisation of team members such as environmental health officers and nurses in the clinics. This effective utilisation is further extended to NGO's, youth clubs, churches and others. District health needs can only be met through commitment and inclusivity. A district health manager is expected to be both a leader and a manager, his/her objective should be to achieving the goals of PHC through the maximum use of available resources (A Policy for the Development of a District Health System for South Africa, 1994: 47-48). This means that the roles and responsibilities of DHM should be orientated around PHC principles, good leadership, clear delegation of authority, supervision and incentives (Gaede et al, 1998: 3-5).

3.8.5   DELEGATION

Job descriptions of all the district health officials should be clearly formulated. It is possible in some instances that the district health manager will be engaged with other commitments. In order to ensure continuity, responsibility needs to be given to subordinates. According to Green (1994), delegation serves various goals, such as stimulating the interest of subordinates in their daily work, and making the work more interesting. It also serves as a means to give relevant subordinates the opportunity to increase and develop their self-confidence under the guidance of their superior, in order to equip them for higher positions. The researcher is of the opinion that necessary training needs to be developed before implementation of any delegated authority and is of the view that managers should not institute this process as a means of escaping effective and efficient responsibility.

3.8.6 SUPERVISION

Kielmann (1991: 40-41) says supervision is one of the crucial components of management. It is supposed to be a two way learning process, instead of being an inspection orientated service. The main function of supervision at a district health level is to maintain and improve the quality of health care. Frequent visits are required for the success of this process. These visits will also help in giving information on improving PHC management and to ensure that resources are allocated effectively. The supervisors should be a living example in this process. They are expected to be innovative and flexible. The peculiarity of an area and resources available should be taken into consideration during the process of supervision. According to Tarimo (1991: 85), the onsite visit should act as a form of motivating the staff, and should be used to collect information on some of the following issues:

- What population is served?
- How is the work organised?
- Are outreach activities currently provided?
- What problems hamper the current operation of the facility?
- How is the staff tackling these problems?

3.8.7 INCENTIVES

Tarimo (1991: 86) states that it is unrealistic for a manager to expect good performance under difficult conditions from workers who are poorly rewarded. Low morale is regarded as one of the contributing factors in delays in meeting the health needs of the population. Amonoo-Lartson (1984: 161) is of the view that promotional opportunities should encourage workers to be more responsible within their organisations. He further argues that areas such as work performance and the programme towards the personal development of the staff need to be always in the minds of health managers. Several alternatives means of reward need to be explored – either financial or status-related

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rewards. The researcher is of the opinion that rewards might encourage health professionals to work even in rural areas.

3.8.8 SUPPLIES, LOGISTICS AND MAINTENANCE

A clear way of procurement, distribution transporting and maintenance will have to be established. These systems are expected to act as support services in the efficient implementation of PHC. It is one of the principles of PHC to promote equity and accountability around the distribution of health services. According to Tarimo (1991: 88) the following functions need to be reviewed in order to improve logistics:

- Planning and budgeting
- Inventory control
- Records and reporting
- Distribution and transport
- Maintenance and repair
- Communications
- Receiving and inspecting
- Storage and warehousing

Provision needs to be made for the above functions to be fully addressed. It is crucial for management to ensure that the right goods should be in the right place at the right time. It is imperative for the district health management team to ensure that issues such as over-stocking and fraud are prevented at all times. Recording and check-listing systems are essential to promote control around logistic activities. In putting the above debate into practice the following questions need to be asked (Tarimo, 1991: 88):

- Is there a specified supply period?
- Are stock records up to date?
- Is there adequate staff for making requisitions and checking paperwork?

3.8.9   FINANCIAL MANAGEMENT

It is the role of the District Health Team (DHT) to prepare and manage the budget. In order to enhance the effectiveness of budget processing, the DHT should use reliable information about its resources, activities and needs. The budget should give priority to the PHC system, because this is viewed in the DHS as the main source of emphasis. It is at this level that accountability and control should be emphasised. Areas such as timing, expenditure levels, allocations and others are given serious consideration (Tarimo, 1991: 89-90). According to Green (1994), directors act as accounting officers in their institutions; this means that they are accountable for all funds that are utilized by their departments. The researcher is of the opinion that the above views simply suggest that district health managers should be well acquainted with financing processes and procedures, particularly the compilation and execution of annual budgets.

The process of decentralisation is complex, it can lead to difficulties if it is not carried out properly. It is the opinion of the researcher that a strategic management framework need to be developed before implementing this model.

4.   HEALTH SERVICES IN THE CITY OF CAPE TOWN

In this section the researcher will briefly outline historical developments in the CCT with input on the current status quo of the resources that are available in the CCT. Concentration will be given to the following areas:

- Health problems in the CCT.
- Trends in financial expenditure.
- Personnel distribution by personnel category.
- The state of affairs in relation to managerial skills in the CCT.
- The list of PAWC health facilities that are within CCT boundaries.

4.1   HISTORICAL OVERVIEW OF CAPE TOWN

When Jan van Riebeeck landed on the shores of Table Bay in 1652 it was an open piece of land without any infrastructure. There were a few indigenous people who kept cattle and were involved in planting vegetables for subsistence purposes. With the arrival of the newcomers, trade increased between the indigenous people and the settlers. More and more settlers moved in, and the population increased. Through trade and other economic and social interactions between the indigenous people and the new-comers, the population grew fast, and so did the demand for services and infrastructure such as housing, roads, water, sanitation, health and other facilities. It was out of these needs that the city of Cape Town developed (thus providing the required services to the growing population).

For proper administration of the city it became obvious that there should be some form of municipality to administer these services and to generate the revenue required to provide these services. The municipality of Cape Town was established on 3 March 1840 in terms of Ordinance No.1 of 1840. This was almost 188 years after the first settlers had landed in Cape Town (Shorten: 1963, 118).

It is important to note that at that time representation in the local government body was through election by popular vote. To qualify for a vote ".... Citizens had to own or occupy premises to the rental value of 10 pounds a year," (Shorten, 1963:119).

The duration of the period of service for elected representatives was two years. The use of property ownership for participation in the local government automatically excluded those who did not own or rent property to the value of 10 pounds per year – predominantly the Africans and the growing Coloured population.

The first Constitution of the Cape Colony was adopted in 1853. This was a guideline on governance for the colony, and it also contained requirements regarding the ownership or rental of property, in order to qualify to be a representative of the public in any government structure. This also automatically excluded Africans and Coloureds. The first parliament of the Cape Colony included representatives from other Provinces. Again financial qualifications were used "...so that prospective coloured voters were excluded" (Shorten, 1963: 127).

Due to increasing demand for services such as a police service and fire brigades it became necessary that the city should be given the right to raise more revenue. Also in response to the growing demand, Ordinance No.1 of 1840 was amended to form Act No.1 of 1861, which allowed more members to participate. It also made provision for more standing committees to meet the growing demand (Shorten, 1963: 132).

In 1867 Parliament enacted the Cape Town Municipality Act No.1 of 1867, which made Cape Town a fully-fledged municipal government. This accommodated 18 elected councillors (three per district from the six districts). The chairman became the mayor of the city of Cape Town.

The population of Cape Town was growing and so was the need for more services. In response to that need, Parliament passed an act which gave more powers and duties to the Councillors. This act also outlined procedures for future municipalities. In 1883 the town

Council was allowed to levy rates to accommodate the demand for a health service. In 1885 the City of Cape Town formed a department of health services (Shorten, 1963: 144).

In the late 1800's more and more townships (which are now suburbs) were mushrooming around Cape Town. According to (Shorten 1963), this has led to the establishment of an increasing number of municipalities, such as Woodstock, Salt River, Claremont and Rondebosch. In 1901 the population of Cape Town included 5 252 Africans. In the same year, bubonic plague occurred in Cape Town and claimed many lives, especially among the African and Coloured population. When this plague was treated successfully, recommendations were made to develop separate residential areas for coloureds and especially for Africans. It was believed that interaction with Africans would introduce infectious diseases to the white city. This recommendation led to the establishment of Ndabeni Township, which was to prevent Africans from flooding into the central area.

With the discovery of gold, diamond and other minerals in South Africa more and more cities were growing. The struggle between the Afrikaners and the English over the control of South Africa was also intensifying. In 1910 the union of South Africa was achieved and legislation passed in Parliament led to further segregation. In 1936 the Natives Bill was passed which removed Africans from the voters' roll. In 1956 the Separate Representation of Voters Act was passed by Parliament, which removed coloureds from the voters roll (Shorten, 1963:159).

In 1913 Ordinance No.19 was passed, which unified the various municipalities to form the greater Cape Town later known as City Council. The City Council derives its powers from central and provincial legislation. It has its policies and programs and it refers them to the standing committees (Shorten, 1963: 199).

4.2 POST 1994 DEVELOPMENT

The City of Cape Town is a new organisation. It was established under the Local Government Act 209 of 1993, which has the following provisions:

- The act was formed mainly to provide revised interim measures to promote the restructuring of local government.

- The provision of this act applies to all existing local authorities, black local authorities, managed boards, regional service councils and local authorities in self-governing territories.

- Section 13,14 and 15 provide for the repeal of other legislation (most especially those laws which were discriminatory). These include Act 102 of 1982, Act 128 of 1991, Section 28 and 29 of Act 134 of 1992 and other legislation relating to the control of certain areas.

- Section 11 of the Act provides for the establishment of a Local Government Demarcation Board for each province as contemplated in section 124 of the Interim Constitution of the Republic of South Africa of 1993.

The responsibility of this board has been to investigate and make recommendations in writing regarding any demarcation and redemarcation of Local Government areas.

The demarcation board for this province made the following recommendations:

- The 6 substructures and Cape Metropolitan council;
- Central Substructure in which the City of Town falls is one of those 6 substructures, which is a result of the amalgamation of the following local authorities;
  - Cape Metropolitan Council;
  - Ikapa Town Council;

- Crossroads Municipality;
- A portion of the Cape rural area;
- Pinelands; and
- Other parts of the Cape Town Municipality.

After the local Government elections the City of Cape Town was divided into 44 wards. Within the 44 wards, the city of Cape Town serves approximately 1,3 million people. The Metropolitan Labour Council (MLC) and Local Bargaining Council (LBC) were established to facilitate the negotiation process towards the amalgamation of local authorities. Management, unions and politicians are the key players in the MLC's and LBC's.

Some of the key areas discussed by MLC and LBC, are the following:

- Transfer of staff;
- Conditions of service;
- Hand-over process;
- Role of the Cape Metropolitan Council and others.

For the purpose of this paper it is vital to a brief historical background to some of the local authorities, such as:

4.2.1 CAPE METROPOLITAN COUNCIL (CMC)

The CMC was established in the 1950's. It was initially known as the Divisional Council. In 1985 it was renamed by the Regional Service Council Act of 1985 and became known as the Regional Service Council (RSC). The main focus of the RSC was to provide services to disadvantaged communities.

In 1995, the name was changed again as the result of political transformation and the RSC became known as the CMC.

4.2.2   IKAPA TOWN COUNCIL AND CROSSROADS TOWN COUNCIL

For many years these two councils fell under the former Divisional Council and Cape Town Municipality. In 1981 the Bantu Administration board (BAB) was established under the Black Local Authorities Act. The BAB was changed in 1994 and became known as Bantu Administration Development. The reason for this change was to give the body more powers. As highlighted above these were apartheid establishments, which did not make any meaningful contribution to the community. They created duplication, fragmentation and confusion.

4.3   HEALTH STATUS OF THE CCT PUBLIC HEALTH USERS

Annexure 1 gives a summary of health problems that are encountered within the City of Cape Town. Clearly, there are differences in the mortality and morbidity rates within various districts. A major gap is identified between Central and Nyanga districts' top five causes of death. Nyanga district encounters major deaths as a result of homicide and AIDS, while in the Central district, deaths are mainly as a result of cancer and heart failure. The different causes of deaths and illnesses are as the result of disparities in socio-economic status in the City of Cape Town. Whiteside & Hunter (2000: 59 & 64) argues that the legacy of apartheid is a fertile environment for HIV/AIDS rapid spread. They argue that inequality has assisted and continues to assist in the spread of HIV/AIDS, because poor woman had few financial resources and were forced into sexual relationships to ensure the survival of themselves and their children. The researcher is of the opinion that the high infant mortality rate, HIV/AIDS, gastro-enteritis are the indicators for poverty and lack of service delivery.

4.4 THE TRENDS IN FINANCIAL EXPENDITURE

In this part of the research assignment input will be given on how the City of Cape Town's health department is spending its finances. The intention of this part of the research assignment is to give the reader a picture of the CCT's overall health expenditure, input on the money that has been used over the past few years and the priorities of the department.

In the annexure, there is a summary of the health budget for the 1998/99 financial year. There is clear indication that this estimated budget is mostly devoted to personnel expenditure (salaries and wages).

4.5 PAWC FACILITIES

In order to promote comprehensive health services and to end disparities on health it is important for the researcher to include an audit of the services that are rendered by the PAWC. In this part of the research assignment an information will be given on the following issues:

- The primary health facilities that are under the responsibility of the PAWC but are within the geographic boundary of the CCT.
- The personnel employed by the PAWC within this particular local authority.

Annexure 2 of the research assignment gives the reader a picture of the available resources. This information will help in determining whether the available resources will meet the challenges of a DHS as mentioned in Chapter 3. The audit will also help in addressing challenges related to equity of health service delivery in the City of Cape Town.

4.6   THE STATE OF MANAGERIAL SKILLS

In this section the researcher will briefly outline the state of managerial skills within the CCT and PAWC as the main responsible government institutions. According to Fox et al (1997: 4) and Van der Waldt and Du Toit (1997: 180) managerial functions include the following: policy making, planning, leading, organising, co-ordinating, control and evaluation.

Moodley's skills audit report has been conducted in the CCT, which specifies the nature of skills available in particular from the side of CCT nurses. The researcher has realised that qualifications such as Nursing Administration and B.Cur, which have management courses within their curricula, are visible in large numbers in the report. The researcher has gone further in assessing the courses that have been enrolled for between the 1999 and 2000 financial years. These courses include the following:

Diploma in Public Management and Administration,

Diploma in Nursing Administration,

National Higher Diploma in Community Nursing Science,

B Tech Community Nursing,

B Tech Environmental Health,

B Cur Degree,

Masters in Nursing Education,

Honours in Public Administration,

Masters in Public Administration.

DR Jim Te Water Naude from the PAWC states that there are a number of courses that are conducted by the PAWC's human resource training department, such as a supervisors' course, quality management, effective communication, interpersonal skills training and others.

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4.7 STAFF DISTRIBUTION AND ALLOCATION IN THE CCT

This part of the research assignment will outline the population of the area, the different categories of staff available in the City of Cape Town and the number of staff allocated to the respective clinics. Based on the information given below the reader will realise that at the time when this data was collected, there was no equitable formula for distributing staff in the CCT districts. This information will be structured according to the four districts in the CCT. This information will be given in Annexure 3.

The reader will realise that the above-mentioned annexure outlines the discrepancies amongst different CCT districts, as far as the distribution of personnel. It is questionable to the researcher, in terms of what indicators or criteria that is used in allocating the staff amongst various districts.

The following chapter deals with the analysis and interpretation of the data that has been captured through the process of interviewing the respondents.

5. ANALYSIS AND INTERPRETATION OF THE RESEARCH FINDINGS

5.1 INTRODUCTION

The researcher targeted a population of 20; all those respondents were reached. The researcher arranged an appointment to meet the interviewees. Questionnaires were left for the few that were not reached through an appointment. The profiles of the respondents are given below.

5.2 BIOGRAPHICAL PROFILE OF THE RESPONDENTS

5.2.1 Gender

Of the 20 respondents 60% were males and 40% females.

5.2.2 Education

Ninety five percent of the respondents had tertiary qualifications and five percent had secondary qualifications.

5.2.3 Ethnicity

Out of the population that was selected 65% were whites, 30% were coloureds and 5% were Indians.

5.2.4 Stakeholders

Two academic institutions, two governmental institutions and three trade union institutions were represented.

5.3 THE POPULATION

The population consisted of stakeholders who have insight into, and influence on the decision making process in the City of Cape Town. The following stakeholders were selected based on certain minimum criteria:

Governmental Organisations: This component included officials from local government and the Provincial Administration of the Western Cape. The key

decision-makers were interviewed, because they are the ones who will decide on whether the DHS must be implemented or not. They included the Chief Director: Health Service, METRO Health Director (PAWC), and the Director for Programme Development. The CCT Health Director, Acting Manager: Personal Health, Acting Manager: Environment Health, Chief Administrative Officer and others were also interviewed.

Non-Governmental Organisations: The three NGO's in the study are involved in DHS development in the CCT. They are SACLA, the Health Systems Trust and NPPHCN.

Academic institutions: The University of the Western Cape and the University of Cape Town, which both regularly work in the areas of public and community health.

Trade unions: The three trade unions in the study are involved in negotiations about the transfer of staff, and some are involved in the Bi-Ministerial task team that is aimed at resolving problems that could delay the development of the DHS. The unions concerned are SAMWU, IMATU & PSA.

5.4   ETHICAL CONSIDERATIONS

The researcher had to obtain written consent from the respective authorities before the study survey could be launched for this purpose. Letters were sent to the relevant authorities together with a copy of the research protocol.

Consent was sought from potential participants, to include them in the survey. Before the questionnaires were handled, the participants were assured of the confidentiality of the information supplied by them.

5.5   QUESTIONNAIRE DESIGN CONSIDERATIONS

One major consideration in the design stage of the survey questionnaire was that it should measure what it was suppose to measure (validity). The questions were set in the simplest language possible, and in the language used daily by the respondents

(English). The researcher included closed and open-ended questions. There were seven closed questions and ten open-ended questions. The respondents were given an opportunity to tick where indicated and to give written motivations.

Face validity of the questionnaire was assured by asking the opinion of eleven independent experts in the field of health and by consistent communication with the study leader. This was done in an attempt to evaluate the relevance, reliability, objectivity, simplicity of answering and validity of the questionnaires.

Various areas were considered in shaping the questionnaires, in order to suit the topic, and to unequivocally assess the feasibility of implementing the DHS. The closed questions were categorised as follows: the necessity for DHS, the level of equity in service delivery, obstacles in DHS implementation, the capacity to implement, the state of personnel, the state of finances and assessment in terms of the involvement in decision making.

The categories of closed-ended questions were followed by open-ended questions, where respondents were given the opportunity to raise their opinions and feelings about the issues that have an impact on DHS development in the CCT. These issues include the following:

- the state of integration and co-ordinating of health services in the CCT,
- the extent of community involvement in the health directorate,
- the requirements for DHS implementation, and
- the state of managerial skills, and others.

5.6 DATA ANALYSIS

A questionnaire was drafted in an attempt to address concerns in implementing the DHS. The questionnaires answer a number of questions and areas of concern that were raised in the objectives of the research assignment, intentions of the study and others.

Two types of questions were distributed to the respondents – open-ended and closed questions (Brynard and Hannekom 1997).

90% of the questionnaires were dealt with during an interview. Another 10% were posted to the respondents because it was not possible to make appointments with them.

5.7 RESPONSES CAPTURED FROM THE QUESTIONNAIRES

The researcher drafted 17 questions for the purposes of the interview. The questionnaires were grouped into 2 sections – that is, closed questions and open-ended questions.

5.7.1 CLOSED QUESTIONS

In this section, the researcher will give a summary of closed-ended questions followed by the nature of the response and the percentage. This is intended at giving us a picture about the overall section. An in –depth analysis will be made in all those questions that are viewed as critical towards the implementation of DHS, this will be done in the form of pie charts.

Table 1: *Summary Of The Response From The Closed-Ended Questions*

TOTAL SAMPLES = 20

QUESTION NO.	YES	NO	DON'T KNOW
1. Necessity for DHS	19(95%)	1 (5%)	-
3. Equity in service delivery	4 (20%)	11(55%)	5 (25%)
7. Obstacles in DHS Implementation	19 (95%)	-	1 (5%)
9. Capacity to Implement DHS	18 (90%)	-	2(10%)
10. State of Personnel	14 (70%)	3 (15%)	3 (15%)
12. State of Finance (Financial Constraints)	11 (55%)	9 (45%)	-
15. Respondent involving in decision making	8 (40%)	12 (60%)	-

There were 7 closed questions. Table 1 gives an indication of the nature of the responses to these questions. The researcher will discuss the comments given by the respondents and link these comments with the literature review. The aim of this correlation is to strike a balance between those two environments.

Figure 1: *To Question 1, 95% of the respondents stated that it is necessary to have a DHS in the City of Cape Town. Five percent said it is not necessary.*
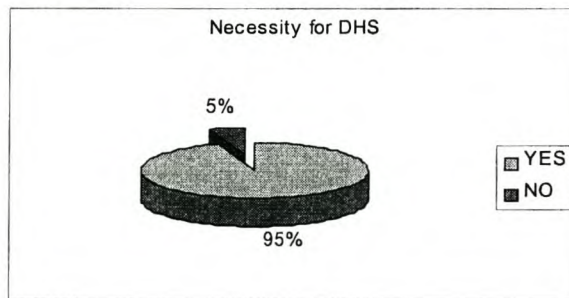
In Question 3, 55% of the respondents felt that the service is not run in an equitable manner. 25% said they don't know, and 20% said that services in the City of Cape Town are run equitably. To Question 7, 95% of the respondents said that there are obstacles to the implementation of the DHS, while five- percent said they don't know.

Figure 2: *In Question 9, 90% of the respondents said that the City of Cape Town does have the capacity to implement the DHS, no respondents felt that the CCT doesn't have the capacity to implement DHS, and ten percent stated that they do not know.*
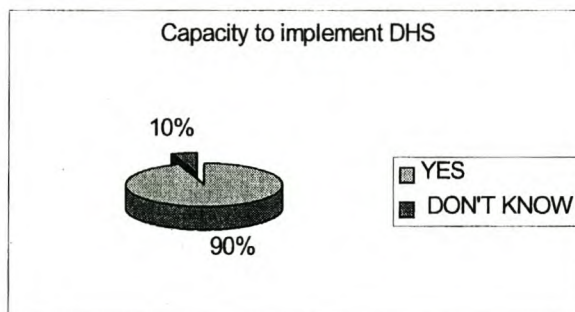
Figure 3: *In question 10, 70% of the respondents stated that the City of Cape Town has enough personnel to implement the DHS, 15% said that they don't know and 15% stated that the city does not have enough personnel to implement the DHS.*
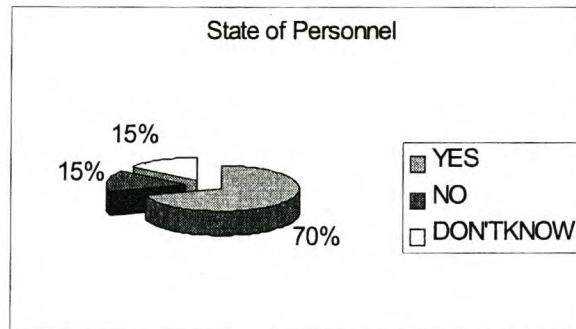
Figure 4: *In Question 12, 55% of the respondents stated that there are financial constraints in implementing DHS in the City of Cape Town, while 45% of the respondents were of the view that there are no financial constraints. No one was undecided.*
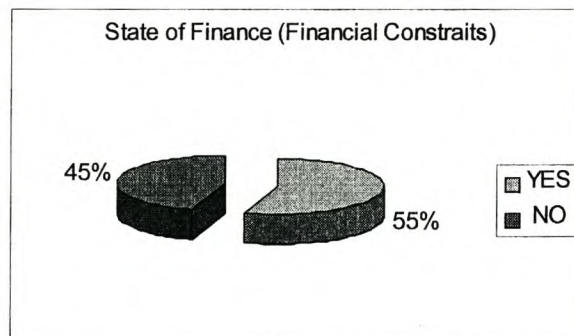
In Qestion 15, 40% of the respondents said that they were involved in the decision-making process on the establishment of the district health boundaries. 60% of the respondents said that they were not involved. No one was undecided.

5.7.2 OPEN-ENDED QUESTIONS

In Question 2, 85% of the respondents stated that there is some form of integration and co-ordination although a lot still needs to be done. 15% of the respondents felt that there is no integration and co-ordinations of health services within the City of Cape Town.

In Question 4, 85% of respondents said that there is a minimum involvement of the community in decision-making. 15% felt that there is no input from the community in the decision-making process.

In Question 5, all the respondents stated that a DHS would lead to effective and efficient delivery of primary health services.

In Question 6, 90% of the respondents had the opinion that the local authority should be responsible for the DHS, five percent were not sure, and five percent felt that it should be the responsibility of the provincial authority.

In Question 8, 100% of the respondents felt that there are resources that need to be in place in order to ensure a well-established DHS.

In Question 11.1 60% of the respondents felt that the health personnel do possess some form of managerial skills. 35% of respondents were of the opinion that there is a full compliment of managerial skills in the health sector, whereas 20% felt that the managerial skills in the CCT are poor.

In Question 11.2, 50% of the respondents were of the view that there is enough knowledge of PHC; 40% felt that there is a need of some re-orientation around this issue. 14% felt that PHC re-orientation needs to be pursued.

In Question 12 and 14, 100% of the respondents felt that there would be a need for support from both provincial and national departments, covering a range of different fields.

5.8   INTERPRETATION OF THE DATA

A majority of the respondents were of the opinion that it is necessary to have a DHS in the City of Cape Town, based on the following arguments derived from their responses:

- All the health services will be managed and co-ordinated in a better way.
- The health service will be accessible to those that are in need.
- The DHS will facilitate the process of community participation and inter-sectoral collaboration
- It will also promote equity and integration of health services.

In Question 2 the input from the respondents concurs with paragraph 3.1 of Chapter 3. Most respondents felt that there is some form of integration and co-ordination of health service in the City of Cape Town. They went further by saying that a lot still needs to be done. The above-mentioned statement is in agreement with paragraph 1.4 and 1.1 of Chapter 1. The manoeuvres made so far in relation to integration of health services are stipulated in paragraph 2.2.

In Question 3 most people felt that the service the City of Cape Town is not yet equitable, although some efforts are in the pipeline. Chapter 4, paragraph 4.7 is an illustration of how staff members are deployed in the City of Cape Town, in relation to the population density. There are 3 EHO's in Nyanga district, which serves a population of 218 000 and experiences a high mortality and morbidity rate as a result of homicide and AIDS. Compare this to the Central district where there are 16 EHO's for a population of 156 000 – differences in health status within the Council prove that services are not distributed in an equitable way). The issue of inequity is also evident in other sectors, such as personal health. The recent report by the CCT director of health provides evidence that there are disparities in the allocation of funds within districts of the CCT.

Question 4 illustrates this clearly. The majority of the respondents are of the opinion that there is minimum community involvement in the decision-making process within

the health sector. There is a feeling that there is a misconception that politicians are taking the role of the health committees, contrary to the NHP or PHP. Two respondents within top management feel that there is no community involvement in decision-making at all. The issue of community involvement in decision-making is treated as a significant on in the development of a DHS development, in the opinion of the respondents.

There is agreement in Question 5, that a DHS would solve most of the problems that have been encountered up to now in the various health departments of the City of Cape Town. The motive given by the respondents is linked with the principal objectives of DHS; these objectives are highlighted in Chapter 3. The respondents feel these areas are: accountability, decentralisation, integration, community participation, equity and accessibility. The response from Question 5 correlates with the motives given in Question 3, 4 and 15. The respondents are of the opinion that all the above-mentioned principles will be easily implemented should the DHS be in place.

The majority of the respondents feel that local government should be in charge of the DHS. The responses from the respondents concur with the recommendations made by the Bi-Ministerial Task Team that are highlighted in Chapter 3, paragraph 3.6.

In Question 7, most respondents felt that there are obstacles in implementing a DHS such as: reluctance to change, lack of political commitment, lack of financial resources in Human Resources, power struggles between the PAWC and the local authority, management's attitude, no legislative framework, lack of leadership, and lack of political commitment. Most of the respondents felt that human and financial resources are the key obstacles in implementing the DHS. The issue of human and financial resources has appeared in most of the responses from the questionnaires. This response is linked with Chapter 1, paragraph 1.2, where it is stated that human resource management and finances are the key obstacles in implementing a DHS. It is important to address these obstacles because there is no policy that can be easily implemented without the availability of finances and sufficient human resource capacity.

In Question 8, all the respondents indicated that there are various resources needed in order to ensure a well-established DHS. These resources range from physical and human resources, to financial information systems, good managerial skills and others. In line with the responses from the respondents, Chapter 3 deals with the areas that need to be addressed in implementing the DHS.

In Qestion 9, 100% of the respondents were of the opinion that the City of Cape Town has enough capacity to implement a DHS. The respondents further argued that the CCT has good administration infrastructure, good experience, sufficient political commitment, support and money. The motivations given by the respondents leave this researcher with no doubt that the CCT will be capable of implementing the DHS. The respondents went deeper in answering this question, listing specific resources such as physical, technical, financial, personnel and others as the main bases for their opinions.

70% of the respondents felt that there is enough personnel in the CCT to implement the DHS. Chapter 4 gives lists the number of the staff employed by the CCT per district. In the research assignment's introductory statement, personnel are regarded as one of the main obstacles in implementing the DHS; this means that serious assessment needs to be made in this regard. The majority of the respondents recognise personnel resources are a concern which needs to be addressed, but they also believe that there are enough personnel resources to implement and sustain DHS. Question 10 is linked with question 11. The results reveal that there are enough managerial skills and the staff is aware of PHC. As far as the respondents are concerned, there is a need to utilise the available managerial skills effectively and efficiently. The respondents mentioned the need for training, and said that management and staff should deal with the decentralisation of powers to the district.

In Question 11.1, 60% of the respondents felt that there are enough managerial skills within the City of Cape Town. The Moodley Report on the enrolment input in Chapter 4 concurs with the above statement. This report illustrates the available managerial skills in the City of Cape Town. In Question 11.2, 50% of the respondents felt that personnel are well acquainted with the PHC orientation. 40% felt that there is some understanding of PHC. This shows that the staff is capable of implementing the

DHS but there is a need for PHC re-orientation in order to promote efficiency and effectiveness in the service. This means that there is a need for good communication between the local authority, provincial and national government. Although there is a need for support from the upper structures the respondents feel that independence needs to be promoted.

The courses that staff members have enrolled in, such as Nursing Administration, National Diploma in Environmental Health, B Tech Community Nursing and others have PHC input on their curricula. Chapter 3 paragraph 3.7 on the training of personnel shows that PHC re-orientation is a prerequisite for a sustainable DHS.

In Question 12, 55% of the respondents felt that there are financial constraints to the implementation of DHS, while 45% felt that there are no financial constraints. When the researcher assessed the respondents' motives, several arguments were captured such as: the problem will be sorted out because the PAWC will transfer its staff and equipment, and will also provide financial assistance. Some respondents felt that this provision by the PAWC would be sufficient to meet the needs of a DHS.

A proportion of respondents felt that while several problems would be encountered in the short term, many of these would be resolved over the long term.

A large number of the respondents felt that it is a high time that the council was run in a cost-effective and efficient manner, to ensure the optimal use of resources.

A number of respondents felt that the council should be creative in exploring other sources of revenue and additional funding.

Question 12 is a complex question. Hence in Question 9, 100% of people said there is enough capacity to implement a DHS. It is complex in the sense that one will assume that the concept capacity will include financial resources. 67% of the top managers in the PAWC and CCT (key decision-makers) believe that finances are not a problem. Overall, no one totally disputed or is strongly disagreed that the CCT and PAWC would be able to cope financially with a DHS. This statement needs to be assessed thoroughly, but at the same time this debate reveals that the financial resources are not

a barrier towards DHS implementation. However, the researcher does not dispute the fact that there are concerns, are based on the lack of trust and transparency among parties, poor communication around this issue and power struggles. Chapter 3, paragraph 3.2 treats finances as one of the important requirements for the implementation and sustainability of a DHS. This means that formal and concrete measures need to be explored to ensure financial sustainability.

In Question 15, 60% of the respondents felt that they were not involved in the decision-making on the establishment of the district health boundaries. The issue of community participation in decision-making is crucial in the DHS, as indicated in chapter 3, paragraph 3.2.

In Question 16, many respondents showed awareness of the number of districts in the CCT. This shows some form of involvement or curiosity on the part of the respondents. The intentions for posing Question 4, 15 and 16 are similar, because they all trying to assess the level of involvement and participation in decision making. It became clear to the researcher that there is minimum involvement and participation of other stakeholders in decision-making. This is contrary to the principles of a DHS as laid down in Chapter 1. These principles promote the involvement and participation of all stakeholders in all the processes that lead to decision-making, such as planning, implementation, and evaluation. The researcher feels that the issue of community involvement is crucial to the smooth running of a DHS, as it will promote good relations between the workers and the clients.

In question 17 most people indicated that they were looking forward to the implementation of the DHS, because they believed it would be a remedy for all the problems that affecting the present health service. This is the dominant view expressed in Question 17, which says that all the health services will be managed efficiently should the DHS be in place. This view falls in line with the input on the theoretical framework provided in Chapter 3 – that the DHS is meant to co-ordinate and manage district health services in a decentralised, comprehensive manner and under one district health manager.

The above-mentioned views in Question 17 concur with the views of Bindari-Hammad and Smith (outlined in Chapter 3), that the DHS is a vehicle for the implementation of PHC. The goals of PHC in general are in agreement with these responses because they promote principles such as accessibility, equity, inter-sectoral action, decentralisation, community involvement and others. This statement shows that there is a link between the theoretical framework on DHS development in SA and the insight of the management.

The scientific facts presented in the analysis and interpretation of the research findings are concise and comprehensive in nature. In the following chapter, a set of recommendations will be made.

6.   RECOMMENDATIONS

Based on the information given in the theoretical framework, the resources available in the City of Cape Town and the response from the respondents, there can be no doubt that it is feasible to implement a DHS in the City of Cape Town. However, it is also the opinion of the researcher that there are still grey areas, which need to be addressed in order to implement a sustainable DHS. The grey areas are the following:

Financial arrangements: An in-depth investigation needs to be made into whether there will be a shortage of finance in implementing the DHS in the City of Cape Town. It seems as if there is uncertainty, mistrust and misconception around this issue. The researcher recommends that a team be appointed to investigate this issue. This team needs to involve all the stakeholders such as unions, NGO's, academic institutions and governmental institutions (local, provincial and national). Transparency and good communication need to be fostered in the process.

Governance: The local government option needs to be implemented as the best method of governance model for DHS in the metropolitan area; this will facilitate decentralisation, people-centeredness and bring accountability into the health system.

Legislative issues: A legislative framework needs to be speedily facilitated by the national health department, so as to avoid contravention of the Health Act of 1977, which is hostile to transformation.

Human resource factors: There is a need for the re-orientation of staff into primary health care; this will help both the local and provincial governments' health personnel to meeting the challenges of DHS and to broaden their scope. There is a need to concentrate on human resource development – areas such as training of staff in customer care, HIV/AIDS, improvement of conditions of service and motivation should be addressed on a continuous basis. District health managers need to be trained in managerial skills – the research has shown that there is a need to develop leadership skills. Efficiency and quality of care will be improved if the staff feel that their needs are also being addressed.

Sharing of information: There is a need to share the experiences that have been encountered by other provinces and countries. The sharing of information will assist in building capacity among the stakeholders and will speed up service delivery. There is a need for ongoing workshops and seminars to ensure that everyone interested is up to date on DHS developments, and to ensure that they are all on board through addressing uncertainties and negative attitudes.

Community participation and involvement: The research has shown a lack of community participation. This needs to be promoted at all cost, as it is one of the building blocks of development. If this is ignored it will lead to disempowerment of the community.

Involvement of stakeholders: Structures need to be put in place to facilitate integration. This means that NGO's, the private sector, trade unions, government institutions (local and provincial) and academic institutions will have to begin communicating in a co-ordinated manner, in order to address areas such as inter-sectoral collaboration, health strategies and priorities.

Inter and intra-sectoral collaboration: Several health problems have their roots in social and economic problems, such as TB, environmental pollution, domestic and sexual violence, HIV/AIDS, alcoholism, drug abuse and high trauma rates. To address these adequately, municipal health services need to collaborate with a wide range of role-players in and outside local government. This principle needs to be promoted at all costs and it requires a serious drive from the top.

Equity: Past and current inequities have resulted in under-provision of services in areas of great need, and relative over-provision in areas where private heath care is accessible and affordable to the community. A review of health service distribution (facilities, staff and resources) needs to be undertaken, and could lead to redistribution of resources. Closure of certain facilities with alternative service delivery options through the private sector, will also need to be considered.

Political commitment: There should be political commitment, that will drive the process. Political leaders must display enthusiasm and a sense of urgency in implementing a DHS.

Negotiations: The resources such as finances, assets and equipment, that will be required from the PAWC and national government need to be negotiated and confirmed on time, so as to avoid unnecessarily high expectations and misconceptions about their role in the development of the DHS.

By applying these recommendations, the DHS objective in the CCT can be achievable. Where the old system neglected particular communities and did not effectively involve the community, the new DHS system would provide more effective and efficient health services to all the residents of the CCT.

7. CONCLUSION

The government of South Africa has introduced the DHS as a vehicle for implementing the principles of PHC. These principles are meant, among other things, to promote the effective co-ordination of health services, to bring health services close to the people, and to promote a comprehensive health service.

The South African government is in the process of implementing the vision of the national Health Department to build a single health service for the citizens of South Africa. The mandate given to the national Health Department is contained in the RDP document viz. that a single national health service should be created with district health authorities as important structures responsible for ensuring access to the delivery of health service.

The Western Cape Province has also been engaged in this process of district health development since 1994, through the development of the Provincial Health Plan. This simply means that the metro and City of Cape Town in particular were involved in the negotiations to put in place the DHS in the Western Cape Province, as mandated by national government, provincial government and other stakeholders.

A Bi-Ministerial Task Team was established in 1997, with the aim of investigating the future governance of all primary health services in the Western Cape Province. This investigation was required to consider the legal and constitutional framework, financial, personnel and service implications, contractual and other agreements, metropolitan and rural differences and time frames for implementation of the DHS.

The City of Cape Town's strategic priorities are in line with the principles of DHS: promoting equity and enforcing the process of integration amongst various departments within the CCT.

This shows that the CCT is committed to the implementation of a DHS. A report recommending that a DHS be developed by the CCT has been submitted by the Director of Health and approved by the politicians (executive committee of CCT and

its council). This report shows that the top management and the politicians of the City of Cape Town support the objective and principles of the district health system.

Transition in local government as provided for in the Constitution, the Municipal Structures Act, the White Paper on Local Government and the abolition of the black local authorities has lead to extensive transformation in local government and the amalgamation of local authorities in the country, in particular in the CCT.

This amalgamation promotes integration, which is the principle of DHS. However, thi issue is complex because despite the amalgamation of local authorities, there are still different conditions of services, disparities in salaries, different pension schemes and different working hours. The result is poor co-ordination, confusion and conflict. It is the intention of the DHS to solve these problems.

Various concerns have been raised, as to whether is there any system can bring equity, accessibility, integration, de-fragmentation, duplication, promote, decentralisation and facilitate inter sectoral collaboration to health service. It has become clear that the DHS is the only health system that will bring beneficial changes to society. This is supported by the theoretical framework provided in this document as well as evidence from the analysis of the responses of the majority of respondents. While there is great need for a DHS, finances form a major constraint.

One of the researcher's concerns was the fact that recommendations made by the finance sub-committee had not been confirmed by the politicians. The response from the chair of the standing committee on health, was that there is a great likelihood that the recommendations will go forward for the following reasons:

- The officials are in constant consultation with the politicians on this matter.
- A consensus has been reached between various stakeholders such as unions, local government, top management, provincial government's top management and others, in terms of how DHS should be implemented in the Western Cape.

The aim of the research assignment was to assess whether it is feasible to implement a DHS in the CCT with special focus on the human and financial resource aspects. The research findings show that it is feasible to implement a DHS, in particular if these resources can be utilised effectively and efficiently. This is confirmed in the BMTT report.

The historical roots and the state of health system in the CCT have been assessed with the aim of tracing the originality of disparities, so as to rectify them. The state of the CCT's health system has been investigated, illustrating that the CCT has good infrastructure and administration in order to implement and sustain a DHS.

The study objectives of the research assignment have been addressed both theoretically and empirically. The researcher is convinced that the research assignment's intentions will be addressed should the DHS be implemented as envisaged, taking into consideration the concerns that have been expressed.

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