MCH91-92-3-3

CONFERENCE ON REGIONAL POLICY

HEALTH DEPARTMENT INPUT

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The attached is a discussion document and not a final ANC Health Department position.

For example the suggestion to put all government health workers (and possibly all other civil servants) on to 3 year renewable contracts, still needs to be debated further. So does the suggestion to delegate the provision of public services to local authorities and/or to private providers through formal contracts.

However the overall structure of the health services and the division of responsibilities between national, regional and district levels is generally accepted. The major responsibilities should be:

National	...	National policy and planning Redistribution of resources
Regional	...	Coordination of all public and private services in region Support of District services Specialist hospital services
District	...	Primary Health Care services including Community Hospital services

The suggested structure and responsibilities of the Regional Health Authority (RHA) are spelt out on page 5.

NB DECISIONS TAKEN ON THE STRUCTURE, POWERS AND FUNCTIONS OF LOCAL AND REGIONAL GOVERNMENT WILL GREATLY AFFECT THE ABILITY OF AN ANC GOVERNMENT TO DELIVER SERVICES TO THE PEOPLE

PROPOSAL for discussion in ANC structures.

THE NHS

STRUCTURE OF THE NATIONAL HEALTH SERVICE

1. OVERVIEW

The need for an NHS and the principles that will guide an ANC government when setting it up are explained in the Health Policy Guidelines adopted at the 1992 ANC Policy Conference. They include a strong commitment to the Primary Health Care approach and are published in the booklet Ready to Govern. This proposal should be read together with those guidelines.

The country will be divided into about 10 Health Regions and about 60 Health Districts. The boundaries of these regions and districts will, as far as possible, coincide with other political and administrative boundaries.

There will be a National Health Authority (NHA) which will allocate the national health budget and will be responsibile for all health care in South Africa. It will develop broad national policies and will monitor and coordinate both public and private health care.

In order to promote both efficiency and local accountability the NHA will delegate responsibilities and allocate funds to each District and Regional Health Authority (DHA and RHA). These authorities will in turn delegate many functions to local Service Providers.

The DHAs will be responsible for comprehensive primary health care services, including community hospital services. RHAs will be responsible for supporting and coordinating DHAs, for specialist hospital services and for monitoring all public and private health care in their region.

Both DHAs and RHAs will receive most of their budgets directly from the NHA. They will be responsible for ensuring services are provided to their people but they will often delegate much of the work (and budgets) to Service Providers.

Service Providers will often be local authorities but may also be non-government organizations (NGOs), groups of doctors or private companies.

DHAs, RHAs and Service Providers will all work within clear policy guidelines or contracts. A written agreement will specify what they are expected to do, how much money they will have to do it and how their performance will be evaluated. Once this is agreed they will be free to get on with the job as they think best.

Figures 1, 2, and 3 are simplified diagrams of how funding, evaluation and worker participation in policy making will occur.

Table 1 gives an outline of how the different levels of authority will be accountable, through their controlling bodies, to the people they serve. Figure 4 shows how structures of government will link to the proposed Health Authorities and Service Providers.

2. BACKGROUND

South Africa needs a re-structured health service that is able:

- To meet the present system as it is and change it into what we want for the future. We have to start from where the service is today.

- To place the main emphasis of the service at the local level. The key structure will be a District Health Authority (DHA) controlled by, and accountable to, local people, and responsible for seeing that services are available. Regional Health Authorities (RHAs) will exist to support and serve the DHAs and to provide specialised services.

- To be as flexible and adaptable as possible so that many different methods of providing and financing services can be used. For example it must allow for a Non-government health organisation or a private practitioner to take part in the public health service.

- To direct money from central government to districts and regions on the basis of population size and health needs. Large communities with many health problems and few facilities will get relatively more of the health budget. This will be the main mechanism of redistribution.

In order to implement national health policies a basic set of national health service targets must be agreed upon and funds allocated to achieve these.

Funds will be directed to DHAs and RHAs with as few conditions as possible so as to encourage local approaches to health service delivery. The NHA will judge DHAs and RHAs mainly by what targets have been achieved with the funds provided.

3. Proposed structure of a national health service for South Africa

See Figures 1, 2 and 5.

4. The District Health Authority (DHA)

The whole country will be divided into about 60 Health Districts, each with its own DHA. A DHA will normally be responsible for all public primary health care services for about 500.000 people in the area of one or more local authorities. The DHA will be controlled by the local authorities within its boundaries who will sit together with major service providers and community organizations as the DHA Board to take all major decisions such as the appointment of senior staff and the approval of the budget. In as much as the local authorities will be truly democratic, the people will control the local health services through the DHA.

In addition to the controlling board, the DHA will have a professional staff who will be responsible for the day to day work. They will manage facilities run by the DHA, collect and collate relevant epidemiological data and organize the training and development of staff in the area. They will also draw up contracts with other service providers to whom services are delegated and monitor their work by means of performance indicators.

Most money for the DHA will come directly from central government. The RHA will not play a major part in deciding how much money a local area will get or how it is spent. The amount of money for each DHA will be decided on the basis of budgets submitted to the NHA but the three main factors will be the population size, the health status of that community and the existing health care facilities in the area. These will be the main tools of redistribution of health care funds.

If local authorities continue, as at present, to raise additional local funds for health services, these funds will also be controlled by the DHA and will be used for the benefit of the whole health district.

The responsibilities of the DHA would be to ensure that there are :

4.1. **Primary care services** for everyone in the area. These services must include immunization, treatment for acute and chronic illnesses, and maternity, school health, geriatric, workers health and rehabilitation services. The facilities will usually include clinics, mobile services and community health centres. See addendum 1 for detailed services.

The provision of primary care services would be guided by national norms set out by the National Health Authority. It is envisaged that DHA's will administer very few services themselves but rather recruit various service providers to do this on a contract basis.

4.2. **Community hospital services.** Most people needing hospital admission have common conditions and will be admitted to community hospitals near their homes and families. These hospitals will also provide 24 hour maternity and casualty care and will be visited regularly by specialists from regional hospitals but will be run by non-specialist doctors. They will be controlled and run by the DHA. In this way local people will play a real part in the management of their local hospital.

The rate of provision of community hospital beds by various categories such a maternity, adult medical, children, etc should be agreed upon with the National Health Authority. If insufficient beds were available in the area it would be possible for a DHA to contract with another authority or supplier to provide the service. Similarly, excess local capacity could be contracted out.

4.3. **Ambulance and other transport services.** Basic levels of provision of these services will be set out at national level with some variation for local conditions. Especially in rural areas a well functioning transport system is an essential part of health care. Adequate funds especially for training of staff and technical backup are essential. In many cases the use of contractors will be appropriate. An example would be the use of taxi services to transport non-emergency patients to hospital.

4.4. **Environmental health services.** These are the services which control the general cleanliness in the community and are involved with issues such as water purity, sanitation, meat inspection, passing building plans as being healthy and so on. The monitoring work is done mainly by health inspectors and the number needed in an area

will vary enormously with local conditions. The number required for a particular area will be agreed with the National Health Authority.

The actual provision of clean water and of sanitation services is often, in a city, a function of the City Engineers department. In peri-urban and rural areas however, and even in some city areas, it is often grossly neglected. The DHA will therefore be responsible for seeing that adequate water and sanitation services are provided.

4.5. **Intersectoral Action** The DHA will be active in liaising and planning interventions with other sectors at the local level for the promotion of community health. This is particularly relevant in the areas of housing and social welfare but it applies also to many other areas. A District Development Committee will be established with representation from local government, from the DHA and from similar bodies in the education, housing, transport and employment sectors.

5. The Regional Health Authority (RHA).

The Regional Health Authority will be responsible for health and basic health services in its region which will be made up of a number of health districts. The population of a region will be between 2 and 5 million.

The RHA will be controlled by a board composed of elected representatives from the local authorities in the region plus a smaller number of elected representatives of regional government. The combined power of the local authorities will therefore be greater than that of the region. The regional tier of government will only have a say in health matters to the extent of its minority representation on the RHA.

In addition to the politically constituted board, a professional and administrative staff will be needed to do the day to day work. The RHA will eventually derive funds for its work mainly from central government. Its main responsibilities will be to ensure that there is:

5.1. **Supervision of and help** to the District Health Authorities in its region. It is particularly important that regionally employed specialists provide support and on going education to medical, nursing and administrative staff in the local areas. For example regionally based medical specialists will visit the community hospitals in the region regularly to ensure that clinical standards are maintained, to set management protocols and to educate medical and nursing staff. In disciplines such as obstetrics, paediatrics and psychiatry, community specialists may be employed specifically to support primary care services in the region. Using regional hospital facilities for training primary care workers is another important area of cooperation.

5.2. **Specialist hospital care** will be provided by the RHA. If facilities are inadequate it will be able to buy services from neighbouring RHA's but an important principle is that essential specialist services should be available within each region. In the past there was too much reliance on providing specialist care only in metropolitan areas, requiring

patients to travel long distances to get essential specialist services. Resources will be allocated to improve specialist services in the non-metropolitan regions.

5.3 **Other specialist care.** Any appropriate health care not available at district level will be procured for patients by the RHA. Difficult operations, specialist consultations, advanced laboratory tests and the supply of hearing aids would be typical examples of this level of care. This care will either be provided by the RHA directly in an institution under its control **or** it will buy the service from an institution outside its authority. It may do this on an individual basis or by having a "bulk" contract depending on the condition.

This ability to buy services elsewhere ensures that every patient has pre-arranged access to highly specialised services wherever in the country they may be provided. For example the Eastern Cape RHA may have a contract with a Bloemfontein hospital to provide a particularly specialised eye operation to patients from its region.

5.4 **For "super-specialist" services** such as open heart surgery and kidney transplants it will usually be the major teaching hospitals in the metropolitan areas that will get the contracts for providing these very specialised services to RHAs all over the country. This will be one of the main ways that the teaching hospitals will be financed.

5.5 **Intersectoral Action** The RHA will actively liaise and plan at regional level with other sectors which influence health. This will be done through a Regional Development Committee similar to the one proposed for each district.

6. The National Health Authority (NHA)

The NHA will take over all health budgets that derive from general taxation, including those that go from central government to local authorities, the provinces, the army, the prisons and the homelands. It will also take over formal ownership of all health facilities owned by any of these bodies. The facilities will be leased to their present owners at a nominal rental for 3 years and within that time a decision will be made whether to renew the lease or to transfer the facility to a District or Regional Health Authority.

The main function of the NHA will be to provide money to DHAs on the basis of population and need. This emphasis on the **LOCAL** level is crucial in redistributing resources according to need. Money will be allocated separately for primary care and for community hospital services, and separately for capital and for operating expenditure. Districts with few facilities will get more money for capital development than those with many facilities.

Money will also be provided to RHAs for their specialist services.

Other important functions will include evaluating national health needs and services, formulating national policy, setting national standards for service provision, implementing a procurement policy for all medical supplies, and defining and collating a basic set of data that will be collected by and from all public and private health care providers.

7. Referral Systems

Good and efficient referral systems are crucial to the success of any health service based on the primary health care approach. Most patients will be seen first at a clinic. From there, most of those who need admission will be referred to a nearby community hospital while a few with very complicated problems will be referred directly to a specialist (regional) hospital.

Some of those admitted first to a community hospital will later be referred to a specialist hospital for particular investigations or treatment, and many of those admitted to a specialist hospital may be referred back to their local community hospital before being discharged home.

Community and specialist hospitals will support each other and both will support the clinics and other primary care providers in their areas. Nobody at a clinic will have to "battle" to get a patient admitted to hospital but they will expect to get feedback later on the appropriateness of their diagnosis, management and referral.

Clear management protocols and regional specialists will both play important roles in this process of on-going education and feedback.

8. Long term employment of staff

All existing staff paid mainly or entirely out of funds coming from central government will be offered 3 year contracts with the NHA. They will be allocated to districts and regions and, to begin with at least, most staff will continue doing what they do at present.

Before the end of these contracts most staff will be offered new contracts with DHAs, RHAs, or service providers. As the division between health authorities and providers becomes clearer less and less staff will be employed by health authorities and more and more by service providers.

Three year contracts that are renewable will give security to staff during transition and will allow local communities, and a new government, to keep staff who work hard and promote the primary health care approach and to drop those who fail to adapt to the new society.

9. Delegation of budgets and responsibilities through "contracts".

All health authorities will be encouraged to delegate as much of their budgets and as many of their responsibilities as possible. The two purposes are firstly to give the people who actually provide services as much freedom as possible to deciside how best to do their jobs, and secondly to make them more accountable to the people they serve. Much of this delegation will be done through contracts.

District and RHAs will often not provide services directly but will instead enter into contracts with a number of organizations (service providers) who are capable of providing

part of the required services in the area. Contracts will be negotiated between the service providers and the DHA and will contain precise details of **what** is to be provided, **how** it is to be provided and **by what** the success of the service will be measured. Contracts will be renegotiated regularly. A service provider who repeatedly does meet the standards set in the contract will not have the contract renewed. The system imposes a good deal of financial and managerial discipline on service providers. The DHA is in turn accountable to the National Health Authority for the use of the funds provided. This contracting arrangement allows flexibility in the use of a range of service providers to meet the service needs of the people of the local area.

Service providers holding contracts with one DHA might include:

- A local authority health department providing clinic services
- A community hospital board
- A non-government organisation (NGO) running a community health centre
- A local authority health department providing environmental health services in the area
- A private ambulance service
- A welfare organisation providing specialised care to the aged

10. The Private Sector

At present most private sector service providers get no public funds directly and do not provide any "public" services. Attempts will be made to draw them into the NHS. The DHA will offer to pay them to provide certain services. For example a group of GPs may be offered an agreed sum to immunize children in a certain area, or the DHA could conceivably offer to pay certain traditional healers to provide some counselling services though funds for this are likely to be very limited.

Private providers who accept government money and do work for the DHA in this way will have moved from being purely private sector workers to being local public service providers.

11. Note on health worker training institutions.

Medical schools, nursing colleges and certain departments in technikons and universities, exist to train appropriate health workers for South Africa. They will not own or run super-specialist hospitals. The National Educational Authority will allocate funds to the medical schools, colleges and department. Tese institutions will then arrange clinical teaching facilities by negotiating contacts with a suitable range of health care providers. Facilities will include clinics and community health centres, and community, specialist and sub-specialist hospitals. This mechanism will make it possible for a remote clinic or rural community hospital to be used as a teaching station by an urban university. This provides a sound organizational base for community based medical education.

Senior staff in the institutions providing clinical teaching facilities could be appointed jointly by the institution and the medical school to ensure high standards of care and of teaching.

Figure 1: Public Funding

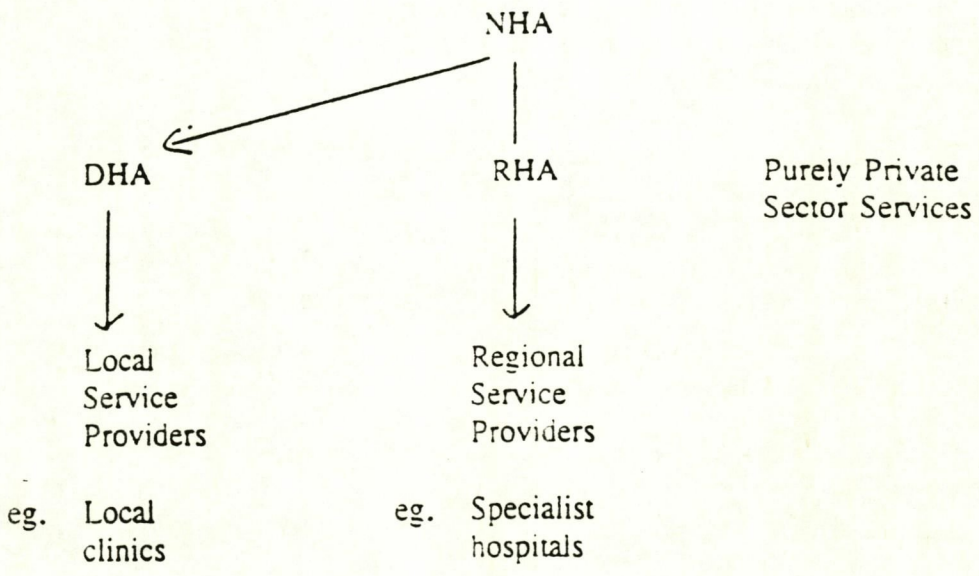
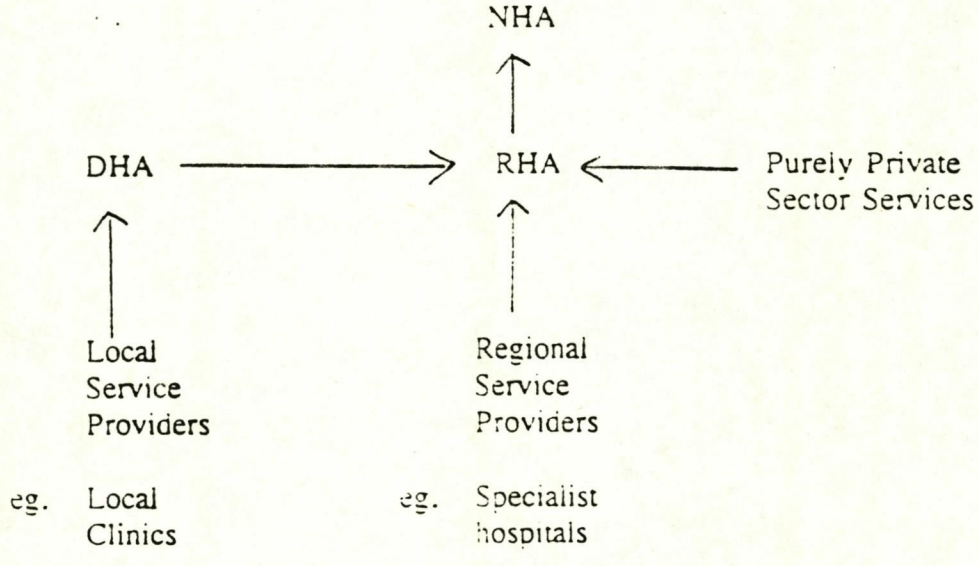


Figure 2: Data Collection and Evaluation



12. Community control

The health services need to be accountable to community structures at district, regional and national levels. This means real political involvement with the power of significant decision making especially in relation to how money is spent.

Through DHA and RHA Boards, democratically elected representatives will be involved in the appointment of senior staff and the setting of budgets. In this way the people will actually control these structures. For local service providers such as hospitals, clinics or community health centres, there should be significant representation from the residents association or civics on the management structure.

13. The Transition

One of the keys to the success of the NHS will be the extent to which existing good services can survive the transition. The emphasis on delegation of responsibility and budgets to DHAs and to local providers of services, allows for considerable local variation and ingenuity in how best to provide services. It is intended to make it easier to move from the present situation to a more coordinated and yet more flexible health service.

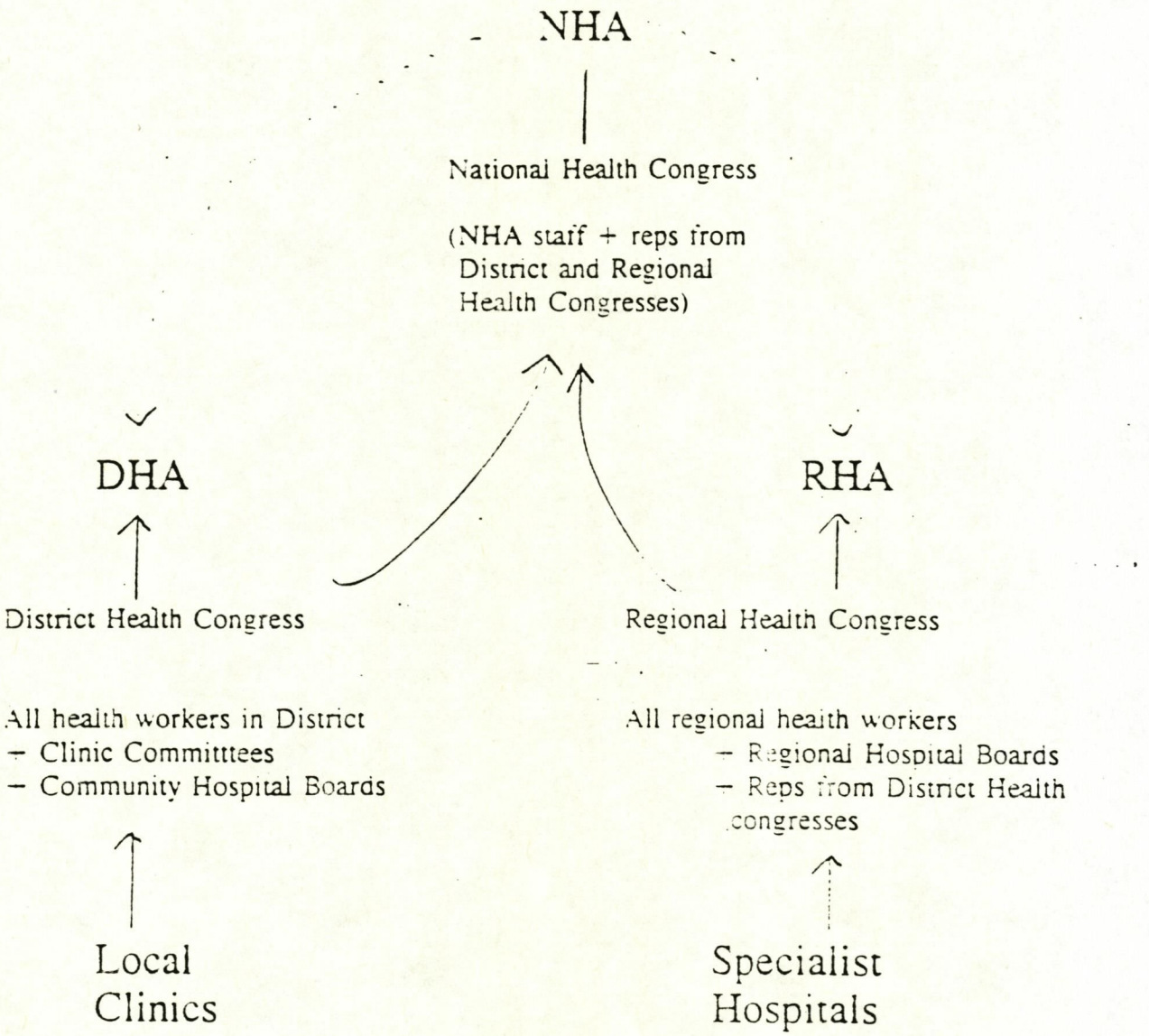
Similarly the proposals on the ownership of facilities by the NHA (section 6), on the long term employment of staff and on the transformation of health worker training institutions should all help to facilitiate the transition.

Nevertheless transition will be uncomfortable for many, particularly for those who are set in their ways. It will require considerable political energy and committment to establish a successful NHS, but in the end the country and all its people will benefit enormously.

Table 1: Political Control

Authority	Controlling Body made up of Representatives of:
NHA	Democratically elected Central Government (Majority) District Health Authorities Regional Health Authorities
RHA	Elected local government (majority) District Health Authorities Regional government
DHA	Elected local government
Clinic Committees Hospital Boards etc.	Majority elected by local community

Figure 3: Worker Participation in Policy Development



Addendum 1

Details of Functions at District Health Authority level.

Comprehensive Primary care.

This addendum sets out the services that should be provided in a comprehensive primary care service. Not all of these services have been provided in the past but this description is in line with world wide concepts of what primary care services should contain. Furthermore these items comprise what communities should be demanding from their health services.

Community level functions

These are the services delivered by a lay or minimally trained health worker who lives and works in the community. One such worker might cover 500-1000 people.

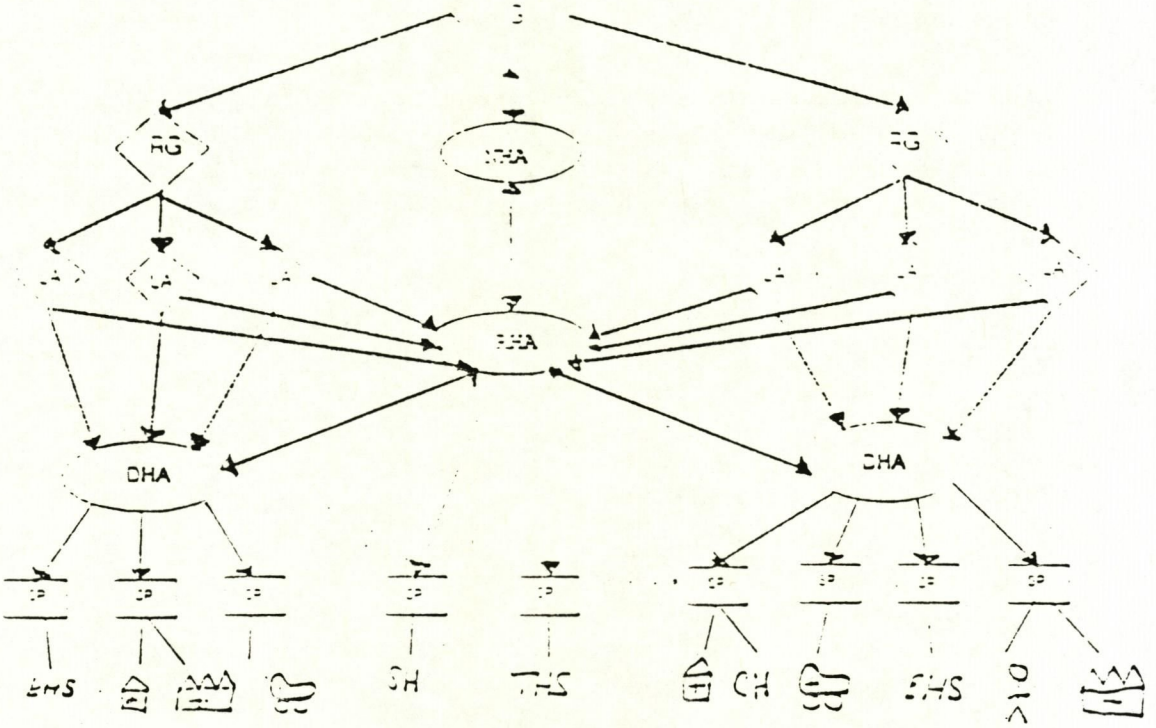
1. Registration of clients
2. Health counselling and advice
3. Problem identification
4. Defaulter tracing
5. Communication to and from the formal health service.
6. Some more specialised functions such as geriatric and disability work by selected workers who have had additional training.

Clinic level functions :

These are the services rendered by a normal local clinic of which there might be one for every 10-20,000 people in an urban area.

1. Immunization
2. Infant growth and development monitoring and maternal counselling
3. Post natal care
4. Antenatal care
5. Contraception services
6. Health education
7. Nutrition support
8. TB treatment
9. Sexually Transmitted Diseases (STD) treatment
10. Disability care in the home.
11. Geriatric care including home care
12. District nursing
13. Acute curative care (excluding casualties)
14. Liaison with community health workers
15. Appropriate data gathering (Not processing)
16. Efficient communication with, and transport to, the next level of health care (community health centre or hospital).

Proposed Health Service Structure



KEY

- Political structure
- Technical authority
- Service providing organization
- Direction of political influence
- Budgeting/funding
- Contracts

- CH Community hospital
- CH Specialist hospital
- THS Tertiary hospital service
- Ambulance service
- EHS Environmental health services
- Community health centre
- Clinic
- Community health worker

- NG National governmnet
- RG Regional government
- LA Local authority
- SP Service providing organization

- NHA National Health Authority
- RHA Regioal Health Authority
- DHA District Health Authority

very limited in the National Health Service.

Environmental Health Services Functions

1. Monitoring of water supplies and sanitation and provision of appropriate services where necessary
2. Licensing of trading premises
3. Monitoring of food handling premises
4. Monitoring of air, water and noise pollution
5. Building plans supervision
6. Housing conditions supervision

Community Hospital Services

Ambulance services

ADDENDUM 2

Detailed functions of the National Health Authority:

3.1 To formulate national health policy including the education of health personnel.
3.2 To determine national health needs.
3.3. To allocate national health finances (as above).
3.4. To determine a set of national service provision standards eg for the ratio of clinics to population, target infant mortality rates etc.
3.5. To determine a set of health indices to be gathered at various levels of the health service by means of which the national health will be monitored. These indices will form the basis of information collection at all levels of the service.
3.6 To implement a national medical supplies procurement policy - this would include medicines and medical equipment.
3.7. To act as the national agency for intersectoral co-operation in matters such as housing and agriculture.
3.8. To respond to disasters

The provision of money to District and Regional Health Authorities will be the main instrument for the carrying out of National Health policies.

Within the National Health Authority certain divisions or "clusters of activity" will be established such as "rehabilitation services" or "mother and child services". These divisions will be responsible for monitoring needs and services in their field and for reviewing all DHA budgets to ensure that adequate provision is made for these services. The divisions will however be purely functional within the NHA and they will NOT establish vertical programs in the districts and regions.

The professional staffing of clinics is based on the various categories of nurse including those with community health qualifications.

Community Health centre functions

A community health centre (such as the Alexandra Health Centre or a Cape Day Hospital) should be provided for every 50-200.000 of the population in an urban area depending on the density of housing and transport facilities.
The services rendered by such a centre include all those provided in a normal clinic but in addition encompass :

1. A clinical service based on doctors and advanced Primary Health Care Nurses who see patients referred by clinics as well as difficult cases for on going care. eg cardiacs. disability etc.
2. Some specialised clinics including for example high risk antenatal care, developmental assessment of children and asthma.
3. 24 hour maternity and casualty services
4. Facilities for overnight admission of a limited number of patients.
5. Practical involvement with the training of all categories of clinical health workers.
4 A simple Laboratory service
5 A basic X-ray service
6. Rehabilitation centre for disabled adults and children.
7. Efficient communication to levels of the service above and below.
8. Transport of patients to hospital or to clinic.

The professional staffing of such centres include the following categories :
General practitioners. dentists/dental assistants/.Primary Health care Clinical Nurses. Physiotherapists, Occupational therapists. therapy assistants. nurses. radiographers and laboratory technologists.

At present in the Transvaal this level of service is not very often available in one centre. Usually the services are fragmented and provided at hospital outpatients and/or by special departments such as the regional offices of the departments of health. In the Cape Province the Day Hospitals Provide many of these services under one roof. A larger community health centre might provide all of these facilities but some of these facilities may be based in the community hospital.

The General Practitioner

It is envisaged that in the distant future comprehensive primary care services will be provided by local teams of health workers that will include several doctors. Such a team would have enough size. staff and facilities to provide the range of services envisaged above for a community health centre. The doctors would not necessarily be the team leaders but they could provide the individualised care and continuity of care which are so desirable but which are not affordable at present. With economic development the community health centre may gradually give way to such group practices. still financed by the District Health Authority.

The place of private practitioners who supply a narrow band of episodic curative care is seen as