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### *Abstract*

*A decentralised District Health System, based on Primary Health Care, is the vision for health services in South Africa. This is established in the National Health Act of 2003. Structures and systems for a district health system have been established; the impact of these structures and systems on human resources has not always been adequately considered.*

*This chapter reviews the current status of the district health system in South Africa and some implications of the National Health Act. Some of the impacts on human resources are discussed.*

# health act and the district health system

## Introduction

*Designers and implementers of decentralisation and other reform measures have focused much attention on financial and structural reform measures, but ignored their human resource implications.<sup>1</sup>*

Riitta-Liisa Kolehmainen-Aitken

In August 1994 the National District Health System Committee was formed with the goal of shifting away from a curative based health system to one based on the primary health care (PHC) approach.<sup>2</sup> The PHC approach has been at the centre of policy formulation since 1994 and the District Health System (DHS) has formally been established in the National Health Act of 2003<sup>3</sup> (Health Act).

These structural processes, however, have progressed in the absence of an over-arching and holistic human resource strategy. As noted by Pick in 2001,<sup>4</sup> human resources are critical to realise the vision of health sector reforms.

The national Department of Health's (DoH) strategic plans for the periods 1999 to 2004, and 2005 to 2009 include some focus on human resource development. In the first period the focus was on strategies for retention of staff and implementing compulsory community service for doctors, dentists, pharmacists and therapists. In the second period, 2005 to 2009, the focus will be on filling of vacant posts and implementing the Human Resource Plan<sup>5</sup> to strengthen human resources for health.

This chapter explores the current status of decentralisation and the DHS in South Africa (SA), the National Health Act (2003), and their possible impact on human resources for health (HRH).

## District Health System and decentralisation

The DHS is a recognised health sector reform process, usually coupled with a decentralisation process of moving health care management from the central to peripheral levels of government.

In 1986, the World Health Organization's (WHO) Global Programme Committee defined the district health system and primary health care as follows:

**A district health system based on primary health care** is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, private, or traditional. A district health system therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities. It includes self-care and all health workers and facilities up to and including the hospital at first referral level and appropriate laboratory, other diagnostic and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities.

**The Primary Health Care Approach** is a philosophy and a conceptual model for an ideal health system. It formed the basis of the 1978 Declaration of Alma Ata which promotes essential health care based on

*practical, scientifically sound and socially acceptable methods and technology, made universally accessible and equitable at a cost that is affordable, with community participation. It includes social upliftment of the community as a whole through, amongst other things, the provision of clean water, household food security, a clean and safe physical environment and mental well-being. The PHC Approach is more than the provision of 'primary level services' that are typically provided in clinics and mobile services. It envisages a seamless referral system from the community all the way to the most sophisticated health care available.*

These definitions are quoted in health policy documents such as the 1994 National Health Plan for South Africa and the 1997 White Paper for the Transformation of Health Services in South Africa.

Decentralisation takes different forms. These include:

- ▶ **Deconcentration** e.g. Responsibility for a tertiary hospital vested in the chief executive officer of that hospital.
- ▶ **Delegation**<sup>a</sup> e.g. Provincial health departments delegating some health functions, such as personal primary care, through signed Service Level Agreements to local government and providing the funding for this.
- ▶ **Devolution** e.g. Municipal Health Services (defined in the Health Act as a range of environmental health services) transferred with full responsibility to Local Government.

In SA, as in most countries, there is a mixture of these types of decentralisation.

With the promulgation of the Health Act a big step has been taken towards establishing a DHS in South Africa. Prior to the Health Act the process of establishing a DHS had been adapted several times, in order to be in line with government policy and to coordinate with other processes in other government sectors.

<sup>a</sup> In South Africa the terms delegation and assignment have been used interchangeably although legally they have different meanings. This has led to confusion over the precise meaning of the terms and even the Health Act uses these terms loosely.

## National Health Act 2003<sup>3</sup>

The Health Act was proclaimed by the President on 19th April 2005 and most elements came into effect from 2nd May 2005.<sup>6</sup> The relevant components of the Health Act for the DHS are discussed below.

### National health department

Chapter three outlines the functions of the national DoH and the Director-General for health. A National Health Council (NHC) is established as the highest health policy making body in the country. The NHC replaces the current Health MinMEC and is required to meet within 60 days of proclamation of the Act; that is by 2nd July 2005. The first meeting of the newly constituted council was held on 6th May 2005. The Composition and functions of the NHC are listed in Table 1. The role of the NHC for DHS development is to advise the Minister on developing guidelines for the management of health districts.

### Provincial health departments

Chapter four outlines the functions of the provincial Departments of Health in each of the nine provinces in SA. The Member of the Executive Council (MEC) for Health in each province ". . . must ensure the implementation of national health policy, norms and standards in his or her province." (Section 25 (1)). This section further outlines the responsibilities of the head of the provincial department of health.

A Provincial Health Council is established in Section 26 and is required to meet within 90 days of proclamation of the Act; that is by 2<sup>nd</sup> August 2005. The composition and functions of the Provincial Health Councils are listed in Table 1. The main role for the Provincial Health Council in DHS development is to advise the MEC on guidelines for management of health district and the implementation of national and provincial policies.

### Health districts

Chapter five of the Health Act establishes a DHS in SA. Section 29 stipulates that each health district is required to have the same boundaries as the local government district and metropolitan municipal boundaries. Section 30 makes provision for the MEC for Health, in consultation with the MEC for local government in the province, to divide any health district into a number of health sub-districts, after taking

into account a number of factors including equity, access to services, quality, and local accountability.

Section 31 provides for the establishment of a District Health Council (DHC) in each health district by the MEC for Health, in consultation with the MEC for local government. Membership and functions of the DHC are listed in Table 1. The key functions of the DHC are:

- ▶ To promote cooperative governance between spheres of government;
- ▶ To ensure coordination and integration of services within the health district; and
- ▶ To advise the MEC for Health, through the Provincial Health Council, of any health matters relevant to the health district.

The DHC must also advise the municipal council on these health matters.

Provincial health legislation is required to provide for the functioning of DHCs in the province and for the approval *“... of the detailed budget and performance targets for health services in the health district to which both the provincial and municipal spheres of government must contribute;”* (Section 31, (5b)). In order to comply with this all provinces will have either to amend their current legislation or pass new legislation.

## Municipal health services

Municipal health services (MHS), according to the Constitution of SA, are a local government responsibility.<sup>7</sup> MHS is defined in the Health Act as elements of environmental health, with the exception of port health, malaria and control of hazardous substances. As a consequence of this definition all other services become a provincial responsibility.

This definition of MHS has given greater clarity to the health responsibilities of the provincial and local spheres of government. The implementation of the Health Act thus requires the devolution of those environmental health functions currently rendered by provincial health departments to district and metropolitan municipalities.

It is envisaged that MHS will be delivered equitably throughout the district and coordinated and funded by the district or metropolitan municipality. These services will be included in the district health plan and will be monitored by the DHC. Staff rendering these services will be employed and managed by the metropolitan (type A) or district (type C) municipality. In some cases the rendering of these services may be delegated to a local (type B) municipality.

## District health plans

The Health Act requires that annual district health plans be prepared under the responsibility of the district or metropolitan health manager (Section 33). The plans are to be drawn up using national guidelines and with *‘due regard to national and provincial health policies and the requirements of the relevant integrated development plan prepared in terms ... of the Municipal Systems Act, 2000...’* (Section 33(1)).

The plans are to include a human resources plan and must be in line with the national budget cycle i.e. they should cover the period from 1 April to 31 March. Currently the national DoH is finalising the guidelines on these annual plans and it is envisaged that district health plans will be formalised with effect from 1 April 2006 and that the first plans in terms of the Health Act will cover the 2006/07 financial year.

The budget and plans produced each year must be discussed by the DHC before being approved by the MEC and the Executive Mayor respectively. These budgets and plans must include at least MHS, all personal primary health care funded by the public sector and district hospital services.

## Community level structures

Community participation, through clinic committees and community health centre committees, is provided for in Section 42 of the Health Act which further states these committees must include *‘(a) one or more local government councillor; (b) one or more members of the community served by the health facility; and (c) the head of the clinic or health centre in question.’* The functions of these committees are to be prescribed in provincial legislation.

Ward committees, established in terms of the Municipal Structures Act, are another community level structure that can be used for addressing problems, including health issues.<sup>8</sup>

These two types of community structures, established by different sectors of government, can function in parallel and are a potential source of confusion for community members in identifying to which structure to report health concerns. A provincial health manager comments that *“since ward committees are made up of people elected on party political line and clinic committees on the other hand are community based, members of the ward committees perceive the others as not having necessary political clout to pronounce on certain issues”*<sup>b</sup>

<sup>b</sup> Written communication with a provincial Deputy Director District Health Services.

**Table 1: Governance structures as prescribed in the National Health Act, 2003**

	Structure and responsibility for establishing	Date of first meeting	Membership	Functions
<b>National Government</b>	<b>National Health Council (NHC)</b> Established by the Act	60 days after proclamation i.e. by 2 July 2005	<p>National:</p> <ul style="list-style-type: none"> <li>◇ Minister of Health – Chairperson</li> <li>◇ Deputy Minister of Health</li> <li>◇ Director General and Deputy Director Generals.</li> </ul> <p>Provincial: from each province</p> <ul style="list-style-type: none"> <li>◇ MEC for Health</li> <li>◇ Head of Department of Health.</li> </ul> <p>Local:</p> <ul style="list-style-type: none"> <li>◇ 1 municipal councillor – representing and appointed by organised local government</li> <li>◇ 1 person employed and appointed by organised local government.</li> </ul> <p>Other:</p> <ul style="list-style-type: none"> <li>◇ Head of South African Military Health Services.</li> </ul>	<p>Must advise the Minister on:</p> <ul style="list-style-type: none"> <li>◇ policy;</li> <li>◇ proposed legislation – national and provincial;</li> <li>◇ norms and standards for health establishments;</li> <li>◇ guidelines for the management of health districts;</li> <li>◇ the implementation of national health policy;</li> <li>◇ the national and provincial integrated health plans;</li> <li>◇ an integrated national strategy for health research; and</li> <li>◇ any other function determined by the Minister.</li> </ul>
<b>Provincial Government</b>	<b>Provincial Health Council</b> Established by the Act	90 days after proclamation i.e. by 2 August 2005	<p>Provincial:</p> <ul style="list-style-type: none"> <li>◇ MEC for Health – Chair</li> <li>◇ Head of Department of Health.</li> </ul> <p>Local:</p> <ul style="list-style-type: none"> <li>◇ One councillor from each metro and district municipality in the province</li> <li>◇ Not more than 3 representatives of organised local government.</li> </ul> <p>Other:</p> <ul style="list-style-type: none"> <li>◇ Others as considered appropriate by the MEC for Health.</li> </ul>	<p>Must advise the MEC on:</p> <ul style="list-style-type: none"> <li>◇ policy;</li> <li>◇ proposed legislation;</li> <li>◇ norms and standards of health establishments;</li> <li>◇ guidelines for the management of health districts;</li> <li>◇ the implementation of national and provincial health policy; and</li> <li>◇ any other function determined by the MEC.</li> </ul>

	Structure and responsibility for establishing	Date of first meeting	Membership	Functions
<b>Local Government</b>	<b>District Health Council</b> Established by Provincial MEC for Health in conjunction with MEC for Local Government	No date set	Provincial: <ul style="list-style-type: none"> <li>◇ Member appointed by provincial MEC for Health as a representative.</li> </ul> Local: <ul style="list-style-type: none"> <li>◇ Member of the Metro or District Council, nominated by the Council – Chairperson</li> <li>◇ Member of each Local Municipality within the District, nominated by the Council.</li> </ul> Other: <ul style="list-style-type: none"> <li>◇ Not more than 5 others, appointed by the MEC for Health after consultation with municipal council.</li> </ul>	<ul style="list-style-type: none"> <li>◇ promote cooperative governance;</li> <li>◇ ensure coordination of planning, budgeting, provisioning and monitoring of all health services that affect residents of the health district for which the council was established; and</li> <li>◇ advise the relevant MEC, through the Provincial Health Council, and the municipal council of the relevant metropolitan or district municipality, on any matter regarding health or health services in the health district for which the council was established.</li> </ul> <p>Functioning to be provided for through provincial health legislation.</p>
<b>Community Level</b>	<b>Community structures</b> Clinic and Community Health Centre Committees	To be provided for in provincial health legislation	<ul style="list-style-type: none"> <li>◇ To be determined through provincial health legislation, but must include:</li> <li>◇ At least 1 local government councillor</li> <li>◇ At least 1 member from the community served by the facility</li> <li>◇ Head of the facility.</li> </ul>	To be prescribed in provincial health legislation.

Source: National Health Act 2003

## Human resources

Chapter seven of the Health Act deals with provision of human resources for health services. The national Minister of Health and the National Health Council are responsible for developing policy and guidelines to ensure adequate human resources are available to provide services. (Sections 48, 49 and 52.) The Minister may develop regulations regarding human resource recruitment, training, retention and management within the national health system, including the DHS. The Minister may also, through regulations ensure that there is definition and clarification of the roles and functions of the national DoH, provincial departments and municipalities with regard to the planning, production and management of human resources.

The provincial MEC for health must ensure that each district prepares and implements an annual human resource plan in line with guidelines from the national DoH director-general.

## Issues arising from the Health Act

### Personal primary health care services

Currently personal primary health care services (PPHC) are rendered and funded by a number of role players including provincial DoHs, metropolitan municipalities, district municipalities and local municipalities. Most of the funding is provided by the provincial DoHs but the metropolitan municipalities also fund significant amounts of PPHC out of their own income.

In terms of the Health Act, all PPHC will become the responsibility of the provincial DoHs, who will be responsible for the funding of these services. However, Section 156(4) of the Constitution requires national and provincial government to assign additional functions to local government if such functions can be better delivered at that level and there is capacity to do so. In addition Section 32(b) of the Health Act states that “the relevant member of the Executive Council **must assign**<sup>c</sup> such health services to a municipality in his or her province as are contemplated in section 156(4) of the Constitution.” (authors’ emphasis). This issue will require further discussion and elaboration so that consistent and coherent application of this legislation can occur.

Currently different provinces and different districts have different approaches in respect to Personal PHC (PPHC). For example in the Western Cape, the provincial health department is absorbing all PPHC staff who are employed by municipalities, local and district, in all the district municipalities. However, in the City of Cape Town metropolitan municipality, a status quo position is being maintained. The Western Cape provincial DoH is funding and providing some PPHC. In addition the Cape Town metro is funding and providing some PPHC. Furthermore, the province is giving the Cape Town metro a subsidy to provide PPHC.

The intention of the Health Act, *in the opinion of the authors*, is for the provincial DoH to be accountable and responsible for ensuring that the DHS works, but that the rendering of these services should over time be decentralised to local government. Unfortunately this is not made absolutely clear in the Health Act. Table 2 shows the planned process as at January 2005 for each province.

<sup>c</sup> The exact implication of this term ‘must assign’ is ambiguous and will probably need to be legally tested to ascertain the meaning.

**Table 2: Summary of provincial plans for personal Primary Health Care and Municipal Health Services**

Province	Personal Primary Health Care Services	Municipal Health Services Staff
Eastern Cape	<ul style="list-style-type: none"> <li>✦ PHC Delegation Task Team consisting of provincial and municipal health officials was established July 2004, to facilitate process of delegation of PPHC to local government.</li> <li>✦ Full delegation of PPHC function to district and metro municipalities planned for March 2009.</li> <li>✦ Joint funding of services to continue.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Moratorium on transfer of environmental health practitioners been placed by Provincial Local Government Bargaining Chamber.</li> <li>✦ Function to be devolved to district and metro municipalities by 1 June 2005.</li> <li>✦ Provincial DoH committed to continue funding until funding arrangements are finalised.</li> </ul>
Free State	<ul style="list-style-type: none"> <li>✦ Staff transferred from four out of five municipalities to provincial DoH.</li> <li>✦ Status quo arrangement remains in Mangaung (Bloemfontein); 'different' process being negotiated for Mangaung.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Provincial DoH to continue funding the service (staff, service and operational) until 30 June 2006.</li> <li>✦ From 1 July 2006 district municipalities to take over the service.</li> </ul>
Gauteng	<ul style="list-style-type: none"> <li>✦ Phased approach to delegate staff from province to municipalities – City of Johannesburg used as pilot.</li> <li>✦ Staff to be seconded until single public service comes into effect.</li> <li>✦ City of Johannesburg – to continue to fund PPHC services until 30 June 2006; then becomes provincial responsibility.</li> <li>✦ City of Tshwane – to maintain current level of funding while service level agreement is being finalised.</li> <li>✦ Ekurhuleni and Sedibeng – to fund services until 30 June 2005.</li> <li>✦ Western District – local municipalities to stop funding PHC after 30 June 2005.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Provincial DoH environmental health practitioners to remain with province to undertake provincial environmental health services.</li> <li>✦ District and metro municipalities to render these services as their core function.</li> </ul>
KwaZulu-Natal	<ul style="list-style-type: none"> <li>✦ Provincial DoH and municipalities rendering PPHC to continue to do so until further arrangements made between provincial and local government.</li> <li>✦ Provincial DoH to not move staff, except on secondment where necessary, until single public service comes into effect.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Provincial DoH in process of finalising service level agreements with district and metro municipalities.</li> <li>✦ Environmental health practitioners employed by provincial DoH refused to be seconded.</li> <li>✦ Rendering of municipal health services to continue as with PHC services. Clarity required.</li> </ul>
Limpopo	<ul style="list-style-type: none"> <li>✦ All PPHC services provincialised, except in Capricorn (Polokwane).</li> <li>✦ All staff appointed to provincial establishment, (without change in salary where difference existed).</li> <li>✦ PPHC to be delegated in Capricorn through a Service Level Agreement.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Provincial DoH to enter into Service Level Agreements with district municipalities to continue funding this service until 30 June 2006.</li> <li>✦ Provincial DoH not to top up disparities in salaries and conditions of service.</li> <li>✦ Some environmental health practitioners to be transferred to municipalities; others to remain to undertake provincial environmental health services.</li> <li>✦ Provincial DoH has developed a new organogram to accommodate the changes.</li> </ul>
Mpumalanga	<ul style="list-style-type: none"> <li>✦ All PPHC services have been provincialised.</li> <li>✦ Transfer of staff from municipalities to province to be negotiated to be on provincial conditions of service.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Province seconding environmental health staff to municipalities but funding to continue through service level agreements.</li> <li>✦ Municipalities to monitor and evaluate MHS.</li> </ul>
North West	<ul style="list-style-type: none"> <li>✦ In 2003 service level agreements for delegation of PHC services to local municipalities in Bophirima District Municipality were agreed to as a pilot.</li> <li>✦ Strategy under review because of the Health Act requirements.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Function and budget to be devolved to district municipalities by 1 July 2005.</li> <li>✦ Staff to be seconded from province to municipalities until single public service is in place.</li> </ul>
Northern Cape	<ul style="list-style-type: none"> <li>✦ PPHC services provincialised in 1996, except in Sol Plaatjie Local Municipality (Kimberley).</li> <li>✦ PPHC services in Sol Plaatjie rendered through 'Gentleman's Agreement'.</li> <li>✦ In other municipalities staff are on provincial DoH establishment but render services in local municipality facilities.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Provincial DoH environmental health practitioners to transfer to district municipalities – about 10 in total.</li> <li>✦ Local municipalities employ most of the environmental health practitioners in the province and fund the services rendered.</li> </ul>
Western Cape	<ul style="list-style-type: none"> <li>✦ Provincial DoH accepted responsibility for funding personal PHC services in non metro areas from 1 April 2005, with necessary funding arrangements.</li> <li>✦ Provincial Technical Team, with Specialist Task Teams for finance and human resources, established in April 2005.</li> <li>✦ In Cape Town Metro PPHC services continue to be rendered and funded jointly by province and the metro.</li> </ul>	<ul style="list-style-type: none"> <li>✦ Provincial DoH and municipalities to continue funding until 30 June 2005.</li> <li>✦ No provincial DoH environmental health practitioners to be moved to municipalities as all are required for provincial environmental functions.</li> </ul>

Source: District Health Systems Directorate: National Department of Health, January 2005



## Cooperative governance

The spirit and intention of the Health Act in relation to the DHS is that there should be cooperative governance between provincial and municipal health departments. This has been the intention of policy documents from the national DoH for the last 10 years and is highlighted in the document entitled Functional Integration.<sup>9</sup> However, this has been a challenge to achieve in most districts.

The challenge continues for all health managers and service providers. New or revised provincial health legislation is expected to assist with clarifying how a functional DHS will be established within each province. In the interim, PHC services within a health district, or sub-district, will need to be managed by an Integrated Health Management Team with representation from all health providers within the district. It is unclear who will head the Integrated Health Management Team. These relationships are illustrated in Figure 1.

The working relationships between the provincial and municipal components of the DHS will need harmonisation as the 'manager for health' in the district will be responsible for drawing up the plans and budgets for the district. Once the plans have been through the DHC they need to be presented to both the executive mayor of the municipality and the MEC for health in the province. This is likely to prove to be a bureaucratic challenge to ensure that these plans and budgets are approved in time for the state's budgetary cycle.

Currently many district municipalities have insufficient resources, financial and human, for managing MHS. Many local (type B) municipalities have greater capacity, and district municipalities may delegate to, or contract these municipalities on an agency basis, to render MHS.

## Role of a district health manager

"Each district and metropolitan health manager must within the national budget cycle develop and present to the district health council in question and the relevant member of the Executive Council a district health plan ...".<sup>3</sup>

The above extract from the Health Act does not make it clear whether the health manager referred to is the provincial manager or the municipal manager and who is actually responsible for the district health plans. In all districts the provincial health department is responsible for the bulk of the district's health services including district hospital services, personal primary health care service, and support

services such as emergency services. The municipal health departments are responsible for MHS.

The district health plans referred to in the Health Act will have to incorporate the services provided by both the provincial and municipal health departments. It is not clear how these plans and budgets will actually be prepared in practice so as to satisfy the legislative requirements as well as being in line with good cooperative governance.

## Progress towards a DHS in South Africa

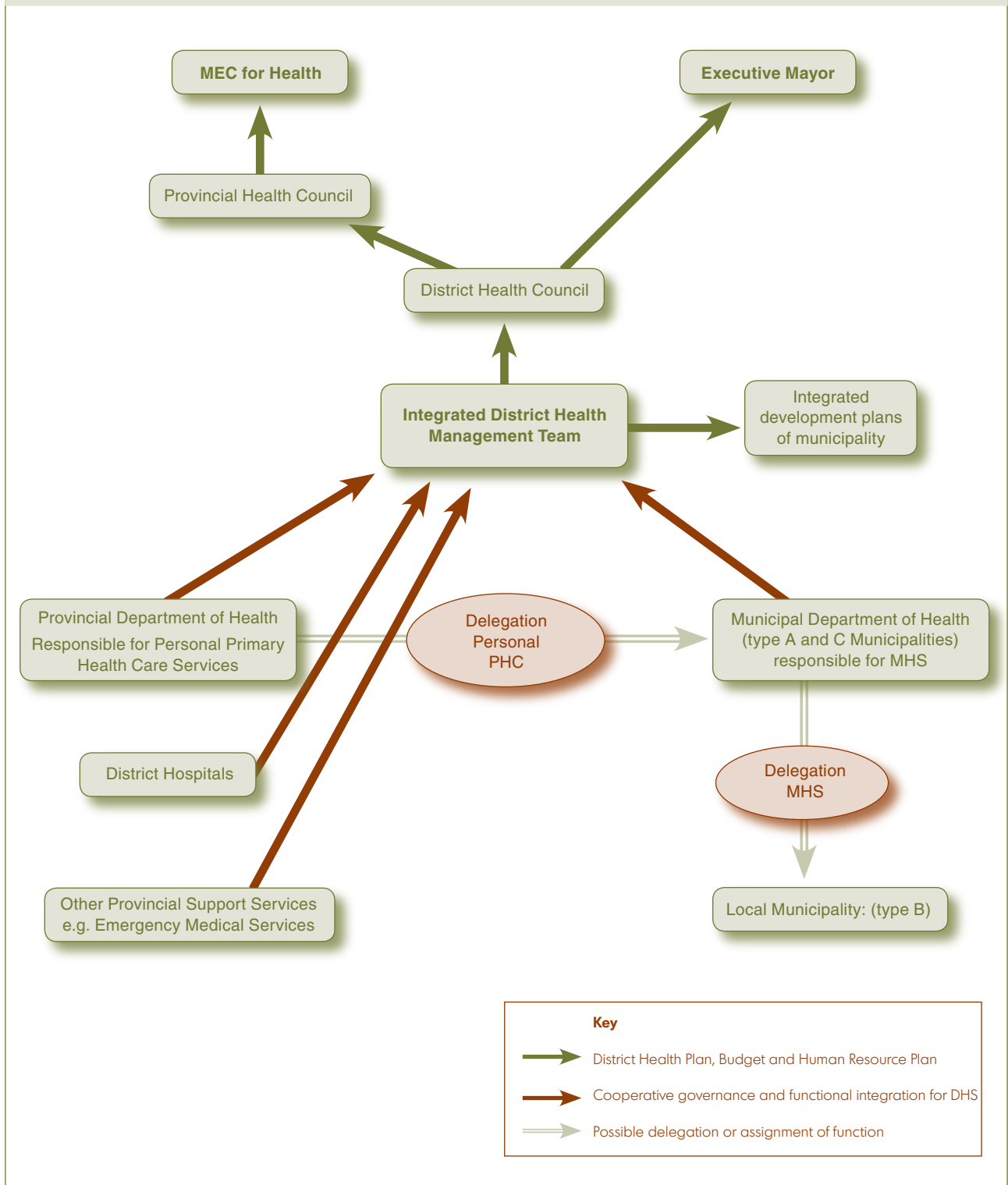
The vision for a DHS in South Africa, as contained in such documents as the ANC National Health Plan, Reconstruction and Development Programme (RDP), and White Paper on the Transformation of Health System in South Africa, is a municipality based service with decentralisation of management to local government. This was affirmed by Health MinMEC in February 2001<sup>10</sup> and is supported by the Constitution of the Republic of South Africa and the National Health Act of 2003.

Decentralisation of health services is not happening in isolation. All government sectors are expected to decentralise to local government matters contained in Part A of Schedules 4 and 5 of the Constitution that '*...would most effectively be administered locally*'. [Section 156(4)].<sup>7</sup> Responsibility for health is split between the three spheres of government. These spheres are '*distinctive, interdependent and interrelated*' (Section 40) and are expected to function cooperatively, as specified in chapter three of the Constitution. These requirements add to the complexity of establishing a DHS in SA. Currently there is still ambiguity as to what should be done in practice in relation to decentralisation of personal PHC from provincial to municipal level. There is uncertainty as to the differences in the words 'assign' and 'delegate' and they are sometimes used interchangeably and sometimes with separate meanings.

Research undertaken in 2003 reported four main obstacles to DHS development:

- Uncertainty over the role of local government
- Persistent capacity weakness in the health system
- A hierarchical and rigid bureaucratic culture
- Some reluctance on the part of provincial governments and health departments to decentralise authority to lower levels.<sup>11</sup>

Figure I: Relationship and reporting lines in DHS



The first of these obstacles has been partially addressed through passing of the National Health Act of 2003. This does not, however, provide clarity on financial and human resource provision. Nor does it clarify the issue related to delegation as discussed above. The other three obstacles remain. In some provinces, the fourth obstacle is a particular barrier to functional integration at a health district level.

The 2003 research also noted that whilst the spirit of the policy is towards a municipal-based DHS the practice may be different:

*'Considering the provincial centralisation already in place, the definition of Municipal Health Services outlined in the National Health Bill may strengthen provincial control of primary health care delivery because PHC resource allocation will primarily be vested in provincial decision makers. However, such control may be important in protecting the equity of resource allocations.'*<sup>11</sup>

Staff employed by provincial and local government feel demotivated by the frequent changes and delays in finalising services to be provided by each sphere of government. There have also been moratoria placed on employment of some categories of staff in both spheres of government until the Health Act is fully implemented. For example, the moratorium on employment of provincial environmental health staff has resulted in a shortage of environmental health practitioners to cope with work demands.<sup>12</sup>

In terms of the Health Act district and metro municipalities are now required to fund municipal health services. District municipalities, in particular, will initially require assistance from external sources such as National Treasury, due to their low revenue base, in order to fund this service. Provision has been made for this to occur, increasing the amount over the next 3 years via the National Treasury which is responsible for disbursing of funds to the provincial and local spheres of government through the intergovernmental fiscal system.<sup>13</sup>

## Resolving human resources issues

A functional DHS requires coordination of health sector structures and resolution of tensions between them. The Health Act has given formality to the framework of the DHS and has created structures. These structures require adequate, skilled personnel to manage them and provide quality health services. As noted by Pick (2001):

*"The challenge facing South African health system is to engage in a strategy that will ensure an adequate supply of people with the requisite knowledge and skills to give expression to the vision of an equitable, responsive health system, guided by the Primary Health Care Approach. However, the provision of such PHC-driven health service, in itself a daunting prospect, needs to occur at a time when resources are, and, will in all likelihood remain, limited."*<sup>4</sup>

Insufficient attention is paid to the implication of health sector reforms on human resources, despite these being the highest cost driver for health services. As Blaauw et al. (2003) noted:

*"There has finally been a tendency to focus on hardware rather than software issues in health system development. Hardware issues include legal frameworks, structures, organograms, financing flows and technical skills development. Software issues cover management styles, communication approaches, relationships, problem solving approaches, building trust. Both are necessary to a health system, with one complementing the other. A focus on one over the other can limit change."*<sup>14</sup>

Unless consideration is given to human resource management and development (not just training), often referred to as the 'software' as well as structures, system and policies, the 'hardware', a functional DHS may remain problematic in SA.

Added to this is a general perception of a poor working infrastructure, lack of supervision and trust, feelings of being uncared for by management resulting in widespread demotivation with subsequent poor service delivery. Gilson (2004) suggests:

*"As the key resource of the health system it is vital that nurses feel valued and nurtured in their work."*<sup>15</sup>

## Single Public Service

The ideal in a fully functional district health system is to have all workers employed by a single employer under the same conditions of service. SA has three spheres of government and currently, because of differing conditions of service and legislative problems, it is difficult for staff to move between local government and the public service (national and provincial government spheres). This is proving to be one of the major stumbling blocks in the way of establishing a functional DHS, the full implementation of the National Health Act of 2003 and the Constitutional requirements for

health services.

The Department of Public Service Administration (DPSA) plans to establish a single public service that encompasses the three spheres of government. This will facilitate transfer of staff between spheres and assist with equitable distribution of skills within the public sector. It will also enable the deployment of managers to where they are most needed. The process is complex and requires aligning conditions of service of all spheres of government so as to ensure mobility of staff.

In the national and provincial spheres of government jobs are evaluated, and given a certain weighting which corresponds to a salary grade, which apply uniformly across these two spheres of government. At present each municipality in the country sets its own salary scales and conditions of service, based on local revenue collected by the municipality. A process to consolidate and align local government conditions of service, including pension funds, is part of the larger process towards building a unified public administration. These changes are a step towards creation of a single public service.<sup>16</sup> The date for finalising the single public service has not officially been set, but is generally not expected to be before 2008.

In her introduction to the 2005 State of the Nation Debate, the National Minister for Public Service and Administration said:

*"We are proceeding apace with giving effect to the provision of the Constitution that deals with the creation of a single public service. We are working towards creating a public service that embraces all three spheres of government, unified in terms of the goals that government pursues and in terms of the systems that underpin its work."<sup>17</sup>*

A single public service will resolve many of the current human resource issues. It will bring to an end the uncertainty in employment conditions of many health workers and will facilitate the movement of public servants between the spheres of government. It will be a step towards achieving the ultimate goal of seamless service delivery through having a functional DHS.

## Conclusion

This chapter has highlighted progress towards DHS and decentralisation of health services in SA, the implications of the National Health Act of 2003 and the impact of the current situation on human resources.

Since 1994 the vision for primary health care has been via a municipal-based DHS. The means of reaching this vision has proven to be very complex. Early policies favoured devolution of all PHC services, including district hospitals, to local government with a District Health Authority responsible for health services.<sup>18</sup> Legislative difficulties were encountered and the framework for reaching the vision has had to change. The changes, however, have been ongoing and frequent.

Nomenclature, for example, has changed. Initially health districts were established within regions in the provinces and the health district size was in line with the WHO definition of health districts with a population size of around 250 000 people. The restructuring of local government and corresponding legislation required that these original health districts change their boundaries to be coterminous with municipal boundaries. In consequence the original 'health districts' now became health sub-districts in most provinces. The consequence of this has had an effect on the morale of staff who have had to face multiple changes in the run up to establishing a DHS.

At a district level, in addition to restructuring challenges in implementing a DHS, there are a number of other pressures. Frontline health workers, mainly nurses, are required to have increasingly complex clinical skills and their scope of practice has widened considerably. They also have to manage a number of new programmes, mainly as a result of the HIV epidemic. The decentralisation of some management functions, including financial accountability, budgeting and planning, has brought an additional burden. There is a shortage of staff and the high turnover results in more pressure on the experienced staff who remains in service.

Structural changes within the department of health include:

- The separation, in many provinces, of district hospitals from the rest of PHC services, with each health district and each district hospital, having a separate budget and management systems.
- Ambulance services, have become a provincial responsibility, with offices in the health districts.
- Laboratory services have been amalgamated into the National Health Laboratory Services (NHLS), a parastatal.

These services, with separate management structures and systems, require functional integration within a health district to provide coordinated service delivery and a seamless referral system to ensure a functional DHS. This coordination and integration can be time consuming for managers with many hours spent in meetings. The budgets, plans and objectives of each of these different services may not complement each other, even though they are based on provincial and national policies and guidelines.

The different conditions of service of provincial and local government health workers remains a problem. The political commitment to develop a single public service encompassing the three spheres of government is encouraging although the long timelines for implementation of the single public service is a concern.

Health worker morale, particularly among front line PHC nurses, is already low and impacts negatively on service delivery. There is a high turnover of staff with movement to the private sector and to developed countries. Factors contributing to the high turnover are not limited to the 'pull factors' of higher salaries and better, more stable working environments. Health workers feel 'push factors' because of the uncertainty of the employing authority in the DHS, the widening scope of practice expected of them, and the lack of transparency in the transformation process. Standardisation of conditions of services and a sense of stability for staff that is expected with a single public service will address some of these negative factors.

If the DHS is to improve PHC in South Africa, the coordination or adaptation of institutional diversity within the system needs to be addressed. Functional integration of these institutions is required, with special attention to human resource management. The DHCs will play a key role in achieving this.

## Recommendations

- ▶ The Department of Health should be actively engaged in the process of assisting in the establishment of a single public service. Health workers and other employees need to be informed of the process and deliberations around a single public service so as to alleviate some of the anxiety caused by uncertainty for the future.
- ▶ Until such time as the single public service is in place there will be a need for better cooperative governance and there should be a strengthening of functional integration of all institutions and structures providing services within a health district, through applying the principles of Functional Integration developed by the national Department of Health.<sup>9</sup>
- ▶ Open lines of communication between managers and front line workers should be created. This will help to share the process of transformation and proposed changes, particularly in the area of human resource management. An environment of trust in which health workers feel valued is required.<sup>15</sup>
- ▶ Community members and structures should participate in discussions on transformation and integration of services. Health governance structures, for districts and local health facilities, should be institutionalised, as prescribed in the Health Act, as a matter of urgency. These will assist with keeping communities informed of changes in health services.

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