

The District Hospital as an integral part of Primary Health Care Services in rural communities

1. Introduction

The Rural Doctors' Association of Southern Africa (RuDASA) has been very pleased with the government's commitment to re-engineering and improving primary health care (PHC) in South Africa. We believe that good quality PHC must be the cornerstone of a well-functioning health care service and that, when done properly, is the most equitable, effective and cost-efficient manner in which to provide good healthcare for all South African, in both urban and rural areas.

We are, however, concerned that the documents pertaining the re-engineering of PHC^{1,2} have not recognised the important role that a well functioning district hospital (DH) could (and in fact should) play within District Health System (DHS) in rural areas to facilitate and strengthen the delivery of good quality, equitable, accessible and comprehensive primary care services, thereby improving the health of all in a district. We argue that unless the management structure in districts is reorganized and rural district hospitals are strengthened as part of the process of re-engineering PHC, the goals of improving primary care will not be successfully realized.

2. The Primary Health Care approach and the District Health System

RuDASA, like the Department of Health, is convinced that the Primary Health Care approach should be the foundational principle on which our national healthcare service is built. Apart from clear international evidence of the effectiveness and importance of the PHC approach^{3,4,5}, it is impossible to work as a rural doctor without quickly understanding the significance of preventive and promotive care, as well as social interventions such as providing clean running water and sanitation.

The District Health System is the vehicle through which the Department of Health has tried to implement Comprehensive Primary Health Care Services in South Africa⁶, and despite massive structural changes that have occurred in terms of district boundaries, provincializing health care facilities and the appointment of District Management Teams (DMT's), the impact on the ground of these changes has, by the Department of Health's own admission been disappointing: "...insufficient attention has been given to the implementation of the PHC approach that includes taking comprehensive services to communities, emphasising disease prevention, health promotion and community participation"¹.

3. Problems with the quality of PHC in rural areas

The experience of the majority of rural doctors is that despite some gains, such as the building of new clinics, significant improvements with regards to access to ARVs, the training of Primary Health Care nurses and better retention of rural clinic nurses due to the Occupational Specific Dispensation (OSD) for nurses, we are still failing to do the basics properly and provide communities with a reasonable standard of primary care services.

The biggest problems in rural clinics that we have received feedback on include the following:

- i) Regular stock outs of basic, essential medicines as well as immunisations
- ii) Poor clinical support for nurses
- iii) Poor logistic support for clinics
- iv) Poor facilities and/or lack of equipment in certain areas
- v) Lack of supervision and poor use of the Community Health Workers (CHW) linked to the clinics.
- vi) Lack of leadership
- vii) No incentives for innovation, or innovations even being suppressed
- viii) Referral difficulties, including transport problems and attitudinal problems on the part of hospitals and of doctors who do not work in the clinics.
- ix) The multiplication of vertical programmes, which is a major challenge undermining integrated quality care

Furthermore, there is very little local ability to analyse data and to use it as an effective management and planning tool, with no understanding of areas of care that should be prioritized in the clinic. Nurses are burdened by a remarkable number of registers and spend much more time filling these out than actually examining patients. There are also unreasonable expectations in terms of statistics that should be kept and relayed to the district office, hardly any of which is fed back to the clinics.

The lack of progress in delivering good quality primary care to communities is evidenced by our poor outcome indicators relative to the amount of money we spend in the public health sector in South Africa⁷. Although the impact of HIV has been devastating to maternal and child health indicators in particular, there is no doubt that, if had we made more progress in delivering good quality, integrated primary care, the indicators would have been less stark.

It has thus been heartening, from RuDASA's perspective, that the DOH has committed itself to the "Re-engineering of Primary Healthcare"; both as an essential aspect of improving health outcomes in South Africa and also as an important precursor to the implementation of National Health Insurance (NHI).

4. Re-engineering Primary Health Care discussion documents

The documents outlining government's plans to re-engineer PHC^{1,2} have much for which they can be commended. The aim of shifting the focus of primary health care services from the predominantly curative towards prevention and health promotion is to be welcomed. Clarifying and standardising the role of community health workers

and using them as part of PHC teams going out into communities has the potential to make an enormous impact if done properly with clear, simple guidelines, good training and proper supervision. Improving school health services should also have significant benefits, especially from an education and health promotion perspective. We are pleased that the mantra of “doing the basics better” is often repeated and that “appropriate and strong leadership” has been identified as the “single most important factor”^{1, p7} in re-engineering PHC. We also believe that the expertise of the district based specialist teams will be valuable in terms of improving clinical governance, setting priorities, supporting district management teams as well as clinicians and providing standardized protocols. There is a risk however that they will perpetuate a vertical, silo-type approach, and not facilitate the integration that is needed to tackle primary care effectively⁸. RuDASA is also concerned about the two following critical aspects of the DHS that have not been dealt with at all.

4.1. Critical Concern no 1: The physical separation of the management of primary health care clinics from the management of district hospitals

Policy documents and journal articles on the topic are clear that the district hospital should form a vital, integrated part of the DHS^{6, 9, 10, 11} yet in practice we find that district hospitals often stand alone and disconnected from the clinics and rest of the primary health care services in a district or sub-district.

The situation has been described as follows: “having separate management structures for your hospital and for clinics would be like a human body having one brain that controlled your legs and another brain that controlled your arms - it could work, but it would never be as good as one brain coordinating all limbs”¹²

In rural districts this illustration above describes the norm, with poor vertical integration of health services, poor co-ordination of care, poor supervision and accountability and the waste of scarce resources. As the Disease Control Priorities Project (DCPP) asserts: “failure to recognize the interrelationship between local- and district-level facilities has resulted high health costs and inefficiency”^{10, p1}

In rural areas, these inefficiencies are particularly pronounced: the offices of district and sub-district management teams are sometimes situated up to 100km from rural district hospitals, with some of the clinics that are meant to be supervised from there even further away than the district hospital. As a result:

- i) Co-ordination of primary health care between different levels of care within the DHS thus becomes very difficult
- ii) Supervision of clinics is poor, with clinic supervisors visiting less than once a month and providing little or no support to clinic nurses
- iii) Hospital management teams spend hours travelling to meetings and so are often off-site, thereby neglecting their duties at hospitals
- iv) A significant disconnect exists between DMT managers and healthcare workers at the coalface of healthcare delivery, with little understanding by managers of the daily challenges of delivering care on the ground
- v) Poor communication and feedback between the district hospital and the clinics that refer to them.

The literature is clear about the central role of the district hospital in the DHS and that the separation of district hospital management from clinic/PHC management within the DHS is not best practice ^{4,9,11,13}, yet this has unfortunately become the norm in most districts or sub-districts in South Africa.

Furthermore, the primary care management structure, which is organized according to programmes (such as Nutrition or Maternal Health or HAST) results in managers working in “silos” rather than in a holistic, integrated fashion. This has been recognized in the DOH re-engineering documents but has not yet been adequately addressed.

4.2. Critical Concern no 2: The misplaced view that strengthening of the District Hospital equals hospi-centric health care delivery

Our second major concern about the documents on re-engineering of PHC is that that district hospitals appear to have been completely left out, or perhaps forgotten, as important contributors to the process of revitalizing PHC.

This may be due to concerns that, historically the hospi-centric approach to care has been a major impediment to the implementation of the PHC approach and therefore good quality healthcare for all. But if the PHC re-engineering process ignores district hospitals in the fear that we may again become too hospi-centric, we are guilty of throwing out the baby with the bathwater.

RuDASA would like to argue that the strengthening of district hospitals should be an essential element of the process of re-engineering PHC, and that this can be done in a way that is community- rather than hospital-focused. It is clear from WHO, HST, DOH and other documents that the district hospital is seen as a very important part of the DHS^{6, 10, 11, 13, 14,15, 16}, which is, of course the vehicle for delivering PHC. Appropriate, comprehensive, high quality primary health care services cannot be delivered in a district without involvement and the practical support of the well functioning district hospital, for the following reasons:

- i) District hospitals are a very important link in the referral chain. The preventative focus of re-engineered PHC will hopefully, in the long run, decrease hospital visits, but in the short term PHC teams visiting homes will **unearth many patients in need of district hospital care**. As more patients have better access to care, the number needing hospital referral increases, at least in the short term. Unless district hospitals are well staffed and functioning well, there will be no place for patients to be managed or referred on to appropriate higher level care. It is essential that the link is facilitated so that up and down referral happens efficiently and effectively.
- ii) Rural district hospitals are institutions that are often able to attract a core of skilled healthcare workers, such as doctors, occupational- and physiotherapists, dentists, dieticians, social workers, audiologists and speech therapists. This provides a node of expertise, which is able to support clinics and CHC's with training, multi-disciplinary outreach services, logistical support, clinical governance and ensure the maintenance of good clinical standards in the district.

Therefore district hospitals can act as the hub from which primary care services can be supported and even organized¹⁰.

- iii) The roll-out of ARV treatment to clinics has made ARV's accessible for most South Africans and has already had a measurable effect on life expectancy¹⁷. However, ARV treatment can be very complex and clinic nurses need to be well supported by clinicians from district hospitals to ensure that good quality care is provided and patients with complications are managed correctly. Good links between hospitals and clinics or communities, with movement in both directions, are once again essential.
- iv) Because district hospitals receive referrals directly from clinics, it is easy for clinicians at the hospitals to identify areas of weakness and strength at clinics, and where good communication lines exist, provide feedback directly to clinic nurses/health-workers and thereby steadily improve quality of care. Similarly, feedback from the clinics about how services are perceived or problems encountered by patients with the hospital will ensure that the hospital functioning improves. A close relationship allows useful feedback in both directions, and promotes action in response to it.
- v) District hospitals are often closer to clinics and health centres than the district/sub-district office and therefore can serve as a natural meeting point for staff, patients and community members¹³. The rural district hospital is, in fact, (as we will argue later) ideally placed for the supervision and monitoring of health workers in clinics, and for managing health information systems to allow for strategic planning and budgeting^{10,13}. Doctors and other health workers in the clinics need to feel they are part of a larger team; being linked into the hospital enables that. Currently, many doctors working in clinics will do overtime in their district hospitals, but remain disconnected from their peers because they are seen not part of the hospital's medical team, and are paid and managed by the sub-district.

We submit that the rural district hospital should be a key implementing vehicle as the Department of Health tries to improve primary health care delivery, and not the marginal player that it has been relegated to be. This would require a significant change in mindset by provincial and national health managers, as district hospitals are sometimes perceived as undermining primary care rather than supporting it.

We understand why this may be the case when district hospitals are poorly staffed, and/or have leadership who are too hospi-centric. Concern is often expressed that when district hospitals are short-staffed, doctor outreach to the clinics is stopped. However there are examples of rural district hospitals, such as Msileni, Bethesda and Zithulele who commit to clinic outreach no matter how short staffed they are at the district hospital itself. The key element here is that clinical management teams at these hospitals feel responsible for the health of their whole community and not just the patients that walk through the hospital gates. This is in line with the Primary Health Care philosophy, but is unfortunately rare, in large measure because the responsibility of the clinics and primary care has been taken away from district hospitals.

Above mentioned rural hospitals have a core of long-term clinicians, good leadership, are well run and are reasonably well staffed. They have good outreach programmes to their clinics (both by doctors and therapists) and are primary care focused. The outreach visits concentrate on teaching and empowering nurses, building relationships and reviewing more complicated patients that nurses feel unable to manage. The numbers of patients seen by doctors and therapists at the clinic are far less important than the practical and clinical support provided, the relationships that are built and the lines of communication that are opened.

It is clear that in rural areas where there are well functioning district hospitals with a strong core of healthcare professionals, the quality of care at primary health care clinics is significantly better than in areas where the district hospital is functioning poorly, whether due to poor leadership or understaffing or both. **The equation is simple: strong district hospitals with a culture of supporting clinics equals good quality, accessible, cost effective and integrated primary care.**

A final comment about district hospitals: health managers often incorrectly perceive that care at district hospitals is expensive. Although this is true of higher levels of hospital care, particularly tertiary hospitals, district hospitals are on the whole very cost effective if measured by cost per DAILY gained^{10,11,18}, both for inpatient care and essential surgical care such as caesarian sections. It is clear that the district hospital, in the context of its role in the DHS is an extremely cost-effective and a practical platform from which to launch the battle to achieve the priority areas identified by the Minister of Health, namely: decreasing maternal and child mortality, combatting TB and HIV, improving life expectancy and a strengthening health system effectiveness.

5. RuDASA proposals to complement the Re-engineering of PHC plan

RuDASA's expertise and experience is of rural areas, and we understand that the manner in which primary care is provided will differ between cities, peri-urban and rural areas. The following proposals, which we believe are essential elements required for true re-engineering of primary health care to be achieved, are therefore specific to rural districts and sub-districts, but may also be relevant to urban and peri-urban areas. These are meant to be complementary to the DoH Re-engineering of PHC plan:

- i) Relocate the primary health care management teams to the site of the district hospital and ultimately merge the management teams of the clinics with that of the district hospital to form a truly integrated sub-district primary health care management team. Advantages of relocation of PHC offices to the district hospital include the following:
 - a. Much better integration of care between clinics and district hospital, improving the capacity to monitor and improve clinical care at all levels.
 - b. Clinic managers are closer to their clinics and are better able to supervise and provide logistical support.
 - c. There is less of a disconnect between managers and health workers at the coalface of delivery, as managers are at a facility providing care on a daily basis and are more accessible to staff providing clinical care.

- d. Transport can be used for clinical care of patients and outreach, instead of shuttling managers between different offices.
 - e. Procurement can be handled and approved at the district hospital level instead of a distant sub-district office, speeding up delivery of orders.
- ii) Appoint District and Sub-district Managers who are public health specialists and who have the necessary skills and qualifications to properly oversee the health of a district or sub-district.
- iii) Make the Clinical/Medical Managers at District Hospitals, together with the Sub-district Manager (and supported by the Specialist Outreach teams) responsible for the health of **all people** in a sub-district. Clinicians at hospitals responsible for care need to undergo a mind shift so they focus on the health of the whole community and not just patients walking through the hospital gate. This should be driven by performance management agreements and budget allocations.
- iv) Make doctors at the district hospital responsible for the **quality of clinical care** of patients at clinics referring to the district hospital, primarily through support and training of clinic nurses during clinic outreach. Integrate sub-district and hospital staff into one team. In this manner, there will also be good clinical support of the proposed PHC outreach teams.
- v) Strengthen and support district hospitals by:
- a. Strengthening HR systems and funding posts at hospitals using clear staffing ratios so that adequate numbers of clinical staff can be recruited for the number of patients attending hospitals. Staffing ratios also need to allow for outreach by professionals to clinics. Newly recruited staff need to be paid correctly and on time, approval of contracts need to happen promptly and professionals with scarce skills need to be treated as such.
 - b. Paying particular attention to attracting and retaining scarce skills, such as doctors, pharmacists, therapists and professional nurses.
 - c. Providing decent accommodation for staff, especially when proper accommodation outside the hospital is not available, as is the case for many hospitals in former homeland areas.
 - d. Improving lines of communication and support from secondary and tertiary referral hospitals, in conjunction with support from the district specialist teams.
 - e. Ensuring that essential medical equipment is provided to enable clinicians to provide the services outlined in “A District hospital service package for South Africa”⁶ and making sure that medical equipment is serviced regularly
 - f. Making sure that clinicians are involved in clinical governance, training of healthcare workers and planning healthcare services
 - g. Making sure that Emergency Medical Services (EMS) provide reliable and responsive ambulance services to district hospitals and clinics, with a clear complaint procedures and consequences when unacceptable incidents occur.

- vi) Simplify considerably the district health information system (DHIS), focus on a few critical indicators that are in line with national health priorities and make the district hospital responsible for analyzing and feeding back health statistics of a sub-district to clinics and health workers.
- vii) Pay special attention to the way pharmacy services are run, by drastically improving accountability and management of pharmaceutical depots so that essential drugs are provided without interruption. There needs to be proper feedback about stock outs and a list of drugs that may never be O/S must be put together and circulated to clinics and hospitals, with clear reporting mechanism.

6. Conclusion

This document has been put together because RuDASA believes that the current structure of the DHS in which district hospital and primary care management teams are separated from each other is dysfunctional and contrary to international best practice, and because we have the strong conviction that well-run district hospitals are an essential part of a well functioning DHS that provides good quality comprehensive primary health care services. The proposals listed above are meant to complement the governments plan to revitalise Primary Health Care, yet we believe that they are an essential aspect of ensuring improved primary health care services to rural areas. Without considering these proposals and providing adequate funding to improve Primary Health Care, the strategy of re-engineering of PHC will not be successful.

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