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The way ahead for district health systems

The weakest level in most health systems is probably that of the district, and the failings of district services have been cited in attempts to discredit the whole notion of primary health care. A district health system cannot function properly in isolation: in particular it should have firm links with its provincial authorities, and should benefit from the comprehensive involvement of the community it serves.

One way of looking at a health service is to consider it as having the primary function of controlling or treating certain diseases. It may aim to supply a set of nationally decided technical interventions to particular segments of a population in the most efficient and acceptable way possible. This vertical approach to health care, designed to put resources where they are most likely to work in given conditions, can be judged by an objective measurement of whether the interventions reach the right people, whether they work, and whether the diseases or health problems are prevented or controlled.

Alternatively, a health system may be divided horizontally and considered as a series of layers of building blocks with individual structures and functions but adding up and interlocking to form a meaningful whole. Each block may be unique and not just a standard peripheral expression of a single national decision. This approach reflects the idea that, although sick people may appreciate that they have specific diseases, they do not usually diagnose their own illnesses or health needs or approach disease-specific parts of their health service. In practice they are not even sure whether they themselves should deal with their symptoms. Their first response is usually to ask themselves whether they are ill; a local remedy may then be sought. Later, there may be an acceptance that something is seriously wrong and that some inconvenient step is advisable, for example consulting a health worker.

Although building blocks of a health service may be designed so that their general goals and form are consistent with a national standard, their expression in the field is not necessarily always the same. No countries are homogeneous; differences in structure, ethnic background, wealth, geography, disease pictures, and beliefs may influence how health services are delivered. Ideally, this tier conforms to a national standard, and reflects accepted rules of accountability as viewed from the capital, but within each block there should be unique qualities as viewed from the bottom.
Content

There is no widely accepted international model for the peripheral tier of health services—or district health services. Some districts provide services based on the principles of primary health care and some of these have been shown to function effectively and acceptably even when they are in a country with a malfunctioning or passive national health care system. A district health service may be unable to deal with some important problems, the interventions available may be limited, and external subsidy may be required, yet the service may be acceptable to its consumers or providers. On the other hand, a well-planned and adequately funded national health system based on a multi-tiered pyramid of services can, if lacking a well-managed district health organization, be a national economic burden, ineffective in improving health status, and inaccessible to or ignored by a large part of the population.

In many countries the health services do not reach most people because they are too expensive, too distant, or inaccessible or irrelevant for technical, linguistic or cultural reasons. Furthermore, it has become clear that many health interventions have to be performed by people based at home rather than in institutions. Following the emergence of Chinese barefoot doctors, the world has witnessed the arrival on the scene of village health workers, village aides, and health volunteers. These people are expected to link the public at home with the services and are meant to respond to the basic essential health needs of small communities. What these needs comprise is an unresolved question. One limiting factor is the kind of intervention which the workers are allowed to perform or are trained for. Another may be that the services have to be wholly or partly financed locally.

It is generally agreed that health services have to be easily accessible to people and that many conventional clinics or dispensaries do not meet this requirement. However, most health service providers have viewed peripheral care in two ways. It could be a mechanism for easily and cheaply dealing with minor or trivial illnesses or discomforts, thereby releasing health service resources for more serious problems to be handled by specially trained staff. It could also be a way for the health services to keep in direct contact with people, thus allowing interventions that require continuing action to have the widest possible coverage. People could be educated about health hazards and beneficial practices, children could be monitored and contacted when in need of immunization, defaulters with leprosy or tuberculosis could be identified and encouraged, people with diseases such as malaria could be kept under surveillance and treated. In addition there could be a link between the services and community groups when collaborative or group action is proposed for needs such as water supply or sanitation. All this could be done at relatively low cost without major adjustments to the rest of the health system.

When viewed from below, or from the community, there have also been apparent advantages. The health services might actually reach people in an affordable manner and the health workers would be local residents who would understand people’s problems and be able to communicate satisfactorily. Medicines would be available locally and communities might be able to influence the form that the services would take. The prospects were so attractive that many communities, even
very poor ones, were prepared to contribute cash and labour towards their realization.

These two sets of expectations may not appear far apart, yet they differed considerably. From the health service providers’ side it was estimated that peripheral care could cope with up to 85% of the usual health problems of a village. This seemed a big proportion, given that local communities had previously received little or nothing of conventional health care and had largely relied on family or traditional services. In addition, it seemed reasonable that at least some of the village health workers’ time should be spent on national health service priorities such as family planning and elements of vertical disease control programmes. In practice, such service tasks were classed as the main priority, took up much of the peripheral workers’ time, and in some systems neither the consumers’ nor the service demands could be met.

The community viewed the peripheral tier as the entry point into the total health service. Villages perhaps welcomed information on how to deal with diarrhoeal disease, malaria and tuberculosis, they provided that this included life-threatening accidents, emergencies of childbirth, and acute major illnesses. It was accepted that local health workers had to be “user friendly” and at least partly controlled by the community, and that they might not be able to deal with every kind of emergency. However, these health workers were meant to serve as a channel through which other forms of action could be taken. The peripheral tier of health workers could not exist in isolation. They were not a substitute for the health services that others were getting, nor a parallel service, but were a part of the health service and the start of a referral chain.

The suggestion that 85% of demand be dealt with at each level and that 15% of people be referred only works when there is confidence that all or most of the 15% will be satisfactorily cared for. A peripheral service designed to cover 85% of health demands is unacceptable if the 85% does not cover life-threatening events about which people are greatly concerned. However, if the next higher referral level also deals with a further 12-13% of the problems, i.e., 85% of the 15% of referrals, more than 95% of health concerns will be covered. A peripheral village-based tier of health services is acceptable only if it is both an integral part of the community it serves and intimately linked with the next tier of services above it. It cannot stand alone: there must be a support and referral system.

Many health service patterns reflect the referral role and have health workers and facilities in the district whose main clinical function is to deal with numerous kinds of referred emergencies and other difficult problems. Unfortunately, where this is not accepted and applied the result is often a neglected peripheral tier whose workers lack supervision, training and logistical
support, and an over-extended second level that spends most of its resources on vast numbers of outpatients with primary complaints.

There are many situations in which district medical officers, medical assistants, and nurses cannot cope with the 100–200 people who queue to see them each day. These workers understandably cry out for help, more staff and new solutions. It is in such districts that village health workers appear to be of no help or are considered irrelevant. This is the pattern of a malfunctioning system. The suggestion that the solution could be to limit district clinics in order to free resources to support the peripheral level can be greeted with resentment or disbelief. Most district health service directors accept administrative responsibility for the peripheral workers but either reject or are unaware of their responsibility to manage an integrated, coherent two-tier district system.

**Size and boundaries**

If a district health group is to assume responsibility for more than 90% of health concerns it must have boundaries. There can be no perfect size as the boundaries are dependent on the size and accessibility of the population and on the nature of the terrain. If the number of people is relatively small it is hard to justify the cost of a second-level health facility unless the community is isolated. If the population is relatively large the level of demand may require a large, less personal second level of service. This could have advantages in a crowded city but in a rural area with a scattered population could make contact between the people and the two tiers difficult or expensive. Districts with large populations, if adequately staffed, can cope comparatively well with second-level service demands and can employ specialized persons to train, supervise, support and supply the periphery. An argument against such districts is that large health service groupings have a tendency to develop a character of their own and to lose their supporting function. There are too many provincial and teaching hospitals with unserved populations in slums immediately outside their walls.

Existing district and administrative boundaries have to be taken into account. It is absurd to suggest that every sector of the public service should have different boundaries even if the ideal sectoral criteria for size and shape may differ. The result could be chaotic if health had one boundary, water and sanitation another, the police another, and so on. Intersectoral collaboration and response would be difficult. Despite the arguments for an ideal size and configuration of a health district there are usually good grounds for suggesting that boundaries should coincide or be consistent with existing administrative boundaries. Difficulties may arise if these are a legacy of historical accidents or if they fail to reflect major tribal or religious groupings. However, boundaries are usually drawn to accommodate patterns of transport and geography, and can be used even if the areas they enclose need to be broken down into smaller units for health district purposes.
The district hospital

In many countries the community-based district-level services are struggling for recognition and resources in the face of competition from the hospital system. The hospitals often win, frequently having the more senior health personnel and being expected to deal with many of the major life-threatening illnesses. They also have more sophisticated equipment and interventions at their disposal, and being located in major towns or cities they can more easily influence decision-makers. Although this may be viewed by the districts as unfair, it is important to recognize the essential role of hospitals. Without the mechanism for referral from district to hospital, either the districts would have to contain major specialized resources or the health system would have to reject or ignore that part of the technology of medicine which, by its nature, has to be institutionally based. The district and specialized hospitals are the ultimate referral points for sick people who cannot be assisted by a district and they can also provide facilities, such as laboratory and other services. What goes up the system is in little doubt, but what should come down is more arguable. Professional interchange is certainly useful. A district medical officer needs to know what happens to the persons he refers, to have a way to correct and sharpen his clinical skills, and to learn about new drugs or treatments which often work their way down to the district by means of the clinical seniority chain. Whether other types of training and logistics should come down from the hospital is more questionable. In a country which is short of resources it could be dangerous or unfair for a competing consumer, such as a hospital, to be a part of the chain of distribution. A provincial pharmaceutical allocation might include an unfair or unjustified proportion of the types and amounts of drugs required by the hospital. It could be more reasonable for a separate decision to be made by the region or province on the resources to be assigned to hospitals and districts. Each of these segments of the health system could then come to its own decisions, reflecting its own priorities. Similarly, hospital-based training and supervision could emphasize the most frequent conditions and interventions in hospitals, rather than those in the districts. A good case can be made for tying districts to provincial or regional authorities directly, instead of to hospitals.

The location of a hospital is less important than the essential geographical groupings within a district. A hospital has to serve and be accessible to a number of districts but does not have to adjoin all of them. Districts can no more stand alone than can hospitals, and there has to be a linkage between them and the national authority as well as with hospitals. In relatively large countries this linkage is through the region, province or state.

The relationship between district and province

Even with partial local funding a district uses public money and cannot have an unqualified right to demand and spend it only in accordance with local criteria. A district can set out its needs but decisions have to be influenced by what public funds are available, by national and provincial priorities, and by considerations of equity and other issues. The user of public funds has to be accountable, through the province, to the national authority. However, if resources are centrally controlled and need to be accounted for, how can a district respond to local
decisions and peculiarities? This problem can only be resolved by compromise.

National and provincial policies may state that the health service will give priority in the use of resources to such objectives as maternal and child health or family planning. If this is done well, most or all of the available resources may be taken up. However, the local community may feel that the health service was designed for other purposes, perhaps with an emphasis on provision for old people or emergencies, and may therefore refrain from using it. This sort of difficulty cannot be resolved using technical arguments. Compromise is necessary on the basis of such factors as broad agreement about the overall objectives of the service, power-sharing between the system and the consumers, and the reservation of some resources for the fulfilment of district decisions on both priorities and the form that the service should take.

“Selective primary health care” implies a shifting of resources towards certain objectives, decided nationally or internationally, reached by a specified series of interventions known to be cheap and effective, and managed according to nationally agreed methods. In accordance with this concept, it is argued in some quarters that limited public resources should not be used in attempts to solve unimportant or unresolvable problems but should be shifted towards more beneficial things. They should be applied, the argument goes, using a vertical management system, since this is most likely to result in the objectives being achieved. The poorer the country, the less can “waste” be tolerated and the greater is the case for standard management from the top.

The opposing view, which I hold, is that selective primary health care is not primary health care at all. What is being advocated is a series of vertical disease control programmes that can destroy primary health care and set back health development by decades. Malaria eradication failed partly because there was no day-by-day and house-to-house presence in villages, and the present proposals will fail for similar reasons. The candidate diseases, problems, and interventions proposed for selective primary health care are all reasonable selections, but also suggest a certain arrogance as they are based solely on technological reasoning from outside the communities and often do not coincide with the priority concerns of the people. The “temporary” vertical management systems for effecting interventions are devised in accordance with technology costs and with coverage that has been arbitrarily decided at a higher level; by their nature they can destroy or make unworkable a district-level service. With the compromises suggested previously it is reasonable for the same or similar interventions to be advocated at district level but their degree of coverage and form of application should be decided locally.

The province should properly hand down standards that may be an essential part of national policy, including decisions on the size, staffing patterns and roles of a district. Although some latitude has to be observed in order to accommodate local conditions,
these standards may be viewed as constraints. The situation is tolerable if the norms are reasonable, are understood by all, and can evolve over time in the light of continuing evaluation and experience. National decisions on rights and priorities, possibly political in nature, cover such issues as access by women to a method of controlling fertility, and the maximum distance between people’s homes and the nearest health facility. Such sets of policies or directives can concern themselves with the qualities of some interventions. For example, there can be a restricted list of pharmaceuticals or a drug policy, a national policy on what is free and what must be paid for, a rationing system or priority list for conditions eligible for hospital care, or a list of equipment that would normally be supplied to a district health service.

The province’s main role, however, has to be one of encouragement and assistance. There is little sense in having a national drug and equipment policy unless there is also an effective method of supply and logistical support. If district health workers are a specialized group with clinical, management and training functions, there must be a system of in-service training and continuing education which can be used to develop the required qualities in the health professionals who emerge from primary training institutions. Some of this training can perhaps be carried out in specialized in-service centres but to be effective it should be continuously supplemented by the province.

Finally, the province should appreciate and be able to cope with the reality that all districts will be understaffed, undersupplied and, if well run, working at maximum capacity all the time. They do not have the resources to cope with epidemics, special programmes, or gaps in staffing caused by illness or late recruitment of core workers or by courses or holidays. The province should have a resource capacity and a colleague-to-colleague, rather than a paternalistic, relationship with a district. This is not a luxury but a basic need. Those of us who have worked in districts can warmly remember occasions when difficulties have been overcome with the direct assistance of provincial colleagues.

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The weakest level in most health systems is probably that of the district. Few districts have fulfilled the expectations of either governments or people, and consequently there are pressures to change or supplant the services provided. Suggestions have been made for hospital outreach programmes, vertical programmes, adjustments to staffing patterns, and rigid national directives. Meanwhile, the failings of district services have been used as an argument against the whole notion of primary health care. The shift of the power structure towards the periphery, the idea of equity, and the move towards health services with a human face and a local presence are therefore in danger.

But the core issue is that district health services have to be viewed as coherent population-based entities, able to cope with more than 90% of the health concerns of the people. This can only be done by a mix of health workers with different roles and responsibilities who can be closely integrated into a workable system. Such a system requires not only professional skills but also managerial ability and special relationships within the team and between it and the population. Community participation should not be limited to spontaneous voluntary contributions, but should also be a response to an open invitation to the people from the services and their staffs to share power and responsibility in a new way.
The district role of a doctor, medical assistant, nurse, midwife or village health worker is unlikely to be fully accepted or implemented if a district appointment is considered to be the place for an undifferentiated professional from a primary training institution. District roles are specialized, requiring, in addition to primary training, the acquisition of specific skills, including those of management.

A district cannot function properly alone. The critical link is not with the hospital but with the provincial authorities, and here compromises are necessary. For these to be accepted there needs to be a reassessment of the provincial role, the staffing patterns, and the support services of provincial authorities. It is not enough that these authorities should be the bosses to which the districts are accountable.

Even if a district health service is thought of as the primary brick in the health pyramid, the national health service stands or falls as a whole. If a district is the smallest managerial unit it should be planned as carefully as possible, but let us not forget that people want complete structures, not just piles of bricks.

Promotion tactics

If the tobacco industry were in the business of selling sex, it would doubtless argue that the relationship between sexual intercourse and pregnancy was merely statistical.