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# PHC, Alexandra Health Centre

## and some implications for an NHS in South Africa

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### Introduction

In 1978 the World Health Organisation hosted a major intergovernmental conference at Alma Ata in the Soviet Union. The Alma Ata declaration, which emerged from the conference, outlined the basic principles of primary health care (PHC).

Underlying the concept of PHC is the idea that the main roots of poor health lie in living conditions and the environment, and particularly, in poverty, inequity and the inadequate distribution of resources. Part of the process of PHC implementation therefore involves encouraging people to play a greater part in the protection and improvement of their own health.

Furthermore, a PHC service must provide not only curative care, but also incorporate preventive, promotive and rehabilitative interventions such as health education, proper nutrition, and basic sanitation. A PHC based approach therefore involves combining and integrating a range of strategies for the improvement of health. The provision of basic services for the whole population is emphasised, rather than highly specialised and technologically sophisticated medical care.

Central to PHC are the principles that:

- \* the first line of contact between populations and their health services should be the provision of PHC;
- \* that PHC should be practical, scientifically sound and socially acceptable;
- \* that a health team approach rather than a doctor based service should be relied on.

Subsequent to Alma Ata there has been widespread international acceptance of the PHC approach. However, the achievements of many PHC services in terms of improving health, have not lived up to the expectations of many of those who were originally committed to the idea.

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In South Africa the debate around developing an adequate national health service (NHS) has focused on a variety of issues such as the respective roles of public and private health sectors, the financing of health services, the need to deracialise services, and the issue of privatisation. While these issues are fundamental to the provision of decent health services, there is an important need to place Alma Ata and PHC back on the agenda.

This article will address certain issues related to the development of PHC services as the "first-line" component of an NHS. Where applicable, the experience of the Alexandra Health Centre (AHC), the largest non-governmental organisation (NGO) health service in South Africa, will be used as a point of reference.

## **PHC and existing state structure**

The implementation of a PHC based approach would necessitate the creation of a national network of comprehensive PHC centres, providing the first line of contact between the community and the NHS. At present, tertiary hospitals see 30% of all outpatients treated by the government health services. If a PHC network were to be established, it would substantially relieve, if not eliminate, the load on the tertiary hospitals.

However, ultimately the relationship between PHC centres and tertiary hospitals, should be a mutually supportive one. The PHC service would have to provide an integrated referral system. Developing such a system would require the thorough deracialisation and rationalisation of existing government services.

The budget for secondary and tertiary care should be allocated to the primary level which would then purchase tertiary hospital services on a market related basis. This "democratisation" of finances would discourage the tertiary hospitals from wasting scarce resources on problems with low social relevance.

With regard to the training of nurses and doctors, the acceptance of a PHC based approach would require a reorientation towards emphasising the social relevance and appropriateness of medical education. Medical schools, and nursing colleges, for example, should also be under pressure to provide appropriate training. Anomalies like language illiteracy, rural neglect, and sexism, must be addressed with more urgency, not only in curricula, but also via other means such as the nature of student selection criteria.

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## Relationship to the private sector

Despite the fact that it consumes a disproportionately large amount of the total financial resources spent on health in South Africa, it is unlikely that we will be able to do away with the private sector. For one thing it is likely that people will assert that patients should retain the right to buy medical services if they so choose.

In view of this, the question of the relationship of the private sector to an NHS arises. Linked to this is the question of the standard of care which can be delivered by an NHS, and especially by a nursing based service as is the case in a PHC network.

For many, a doctor based service is a prerequisite for adequate standards of scientific health care delivery and cannot be compromised. For others, if due attention is paid to the relationship between doctors and PHC nurses (PHCNs), adequate standards can be maintained in a nursing based service.

There are obviously conflicting views around the question of the quality of care provided by PHCNs in comparison to that provided by doctors. However, the benefit of having a PHCN, who speaks the language of the patient and is not profit orientated, undeniably diminishes the importance of whatever difference there may be in standards of health care delivery.

There have been points in its history when the AHC has been substantially dependent on PHC nurses (PHCNs) and functioned adequately. In Alexandra township a large proportion of residents, if they can afford it, make use of both private services and the AHC. Private doctors and the AHC co-exist on a competitive basis. There appears to be no reason why a PHC service should not function effectively in a competitive relationship with the private sector.

However, for the PHC service to be truly competitive, the private sector will have to take fuller responsibility for paying their own costs. One aspect of this is the cost of training health personnel. A tax on the private sector for health personnel used could be one way of getting the private sector to carry more of this burden.

## Financial implications of the Alex experience

The AHC is located in the largest urban area in South Africa. It has a close working relationship with Wits University medical school, including the contribution of final year students. Due to its unique nature at present, it also manages to secure

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various other benefits. These factors would obviously not operate to the advantage of PHC centres in a nationwide network. Nevertheless the AHC can still be seen to provide us with a basis for generalising about the financing of PHC nationally.

In 1988/ 89 South Africa spent R242.00 per capita, 5.8% of its GNP, on health care. Roughly half of this money was spent by the government and half in the private sector. This means that in 1988/ 89, the South Africa government had in the region of R120.00 to spend on health care for every man, woman and child.

The World Health Organisation recommends that each government spend 25% of its health budget on PHC. If the South African government were to allocate 25% of its health budget to PHC, this would imply that, using the 1988/ 89 figures, there would be R30 for PHC for each person in the country.

Population estimates for Alex vary between 200 000 and 250 000. A 25% allocation from the state health care budget (that is, R30 per person) would therefore provide R6-7.5 million for PHC in Alex. In 1989/ 90 the AHC spent R4 million, apart from capital development. The implication is that an allocation of 25% of present governmental expenditure to PHC would be easily sufficient to finance a national network of comprehensive PHC centres.

This would require long term planning with particular attention to the training of human capital development, such as the training of PHCNs, health educators, administrators, and other technical staff. These challenges would require an additional financial commitment from the state. Nevertheless they cannot be brushed aside on financial grounds alone.

## The question of accountability

In the absence of a strong democratically elected local authority, the AHC has been controlled by a management board, 6 of the 13 members of which are elected at an Annual General Meeting (AGM) at which all Alexandra residents are entitled to vote. Of the remaining 7 places on the board, 1 is elected by the AHC staff, 3 are carried over from the previous board, and 3 are appointed by Wits University for historical reasons.

The AGMs are advertised through the local civic association. Advertising includes a mass distribution of 10 000 pamphlets and well placed adverts in the *Sowetan*. While this has worked reasonably well with increasing attendance at AGMs to over 500 in 1990, there are obvious limits to this type of control. In particular, it does not extend to participation in day to day management or to decisions of a more technical nature.

The size of the Alexandra community obviously places restrictions on

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democratic participation. However, the experience of the AHC seems to indicate that this is not the only obstacle to more thoroughgoing involvement. For one thing the organisation of a modern technological service is made more cost efficient by serving a fairly large community. Furthermore because of a shortage of management skills the number of PHC centres would have to be restricted. By implication the basic PHC unit would have to be a certain minimum size. Economic factors might therefore determine the size of PHC units. This may undermine the possibility of more democratic community participation.

In addition, community control may conflict with democratic management of health workers employed by the board. The AHC experience has highlighted the conflict of interests between health workers and the community they serve. This confirms the need for management to be accountable to the community, and for worker interests to be protected by union organisation.

The present form of community participation at the AHC is an interim arrangement, a response to an undemocratic Apartheid based local authority. The AHC experience suggests that democratically elected representatives can develop expertise in health policy, and thereby have a more meaningful say in the actual direction health care delivery moves in. The onus then shifts onto the local authority to deepen democracy by mechanisms such as regular report backs, recall, etc. While this in no way precludes the possibility of direct participation in decision making in several areas of health care delivery, it seems that indirect decision making via full-time elected representatives, whether at local authority or health centre level, is likely to be the mainstay of meaningful participation for some time to come.

## Conclusion

In this article an attempt has been made to identify some of the areas in which debate and more importantly research needs to move if PHC is going to be properly integrated into a future NHS. Of particular importance is the question of financing the training of PHC personnel; budget allocation to a PHC network based NHS; the problem of standards for a nursing based service; and the challenge of deepening community participation in decision making. On the basis of the framework outlined it would also seem that rather than neglecting PHC as a basis for the future NHS, this should form the mainstay of current research agendas.

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