

# Provision of rehabilitation services within the District Health System – the experience of Rehabilitation Managers in facilitating this right for People with Disabilities

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## ABSTRACT

The South African government has embarked on widescale policy reforms in the provision of essential health and rehabilitation services, especially for vulnerable groups of society. The District Health System was created to improve the efficiency and effectiveness of the health system by transferring authority over decision-making to a more local level. These reforms have resulted in the need to restructure, reorganise and reorientate service providers towards a rights-based approach in the delivery of these services. Primary research, using a qualitative case study method to explore the challenges in implementing policy changes within a rights-based framework, was conducted at a selected urban district in South Africa. Findings show that there were several factors that impeded the capacity to deliver rehabilitation services within the new policy framework at the district level. These factors have constrained successful policy implementation intended to guide rehabilitation services within the public health sector, resulting in the rights-based approach to service delivery being compromised.

**Key words:** Rehabilitation services; rights-based approach; district health system; health reform

## INTRODUCTION

Health, defined as an individual's physical, mental, emotional and spiritual well-being has been accepted across the globe as both a social and economic right<sup>1,2,3</sup>. Policies and implementation strategies adopted by states to ensure that this fundamental right is realised differ from country to country. Although visionary goals of many low and middle income countries, including South Africa, are based on social justice, human rights and equity in access to health care and rehabilitation services, implementation challenges continue to prevent these goals from being met. Without access to adequate, appropriate and affordable health care services, vulnerable groups of society will fall further below the poverty line, reinforcing the vicious cycles of poverty, social exclusion and dependency. People with disabilities are identified as a vulnerable group within the South African society. This paper explores the understanding of the role of the District Health System (DHS) in the health sector as a major policy shift occurs and reports findings on the perceptions and experience of managers who are responsible for the provision of rehabilitation services to people with disabilities. These findings were part of a broader study undertaken in the field of Health Policy and Health Systems research.

## LITERATURE REVIEW

### The changing policy context for disability and rehabilitation

While reforms in the health sector were taking place in many developing countries, the broadened understanding of disability as a development issue further challenged the health sector to not only recognise the rights of people with disabilities, but also to implement changes in the way needs are assessed and addressed. Internationally, a shift is recognised from a narrow understanding of disability as a personal tragedy, requiring an individual medical response to 'fix' the person affected, towards an understanding of disability as a result of more complex systems of social restrictions<sup>4</sup>. In 2006, South Africa ratified the United Nations Convention on the Rights of Persons with Disabilities. This resulted in the introduction into disability discourse and subsequently into public policy, of concepts like 'empowerment', 'participation', 'equal opportunities' and 'social

inclusion' based on a rights-based approach. These concepts are reflected in the social model of disability and are demonstrated in the ongoing debates and power struggles to overcome professional dominance in rehabilitation service delivery. Disability and rehabilitation became complex multi-sectoral concepts internationally, yet continue to be delivered in a uni-sectoral paradigm.

Nationally, policy changes resulted in the functions and scope of rehabilitation services also being reviewed. The disability movement mobilised strongly for the rights of people with disabilities during the policy development stage, culminating in two historical milestones for people with disabilities: (1) the Constitution of RSA (Act no: 108 of 1996) and (2) the White Paper on an Integrated National Disability Strategy (INDS), (1997), which is currently being revised. Disability and rehabilitation moved beyond the health and social development sectors; with education, labour, transport, justice, and housing sectors, as service providers, also mandated to include disability within their programmes. Despite national efforts to integrate disability functions into mainstream policies and programmes, services addressing the needs of people with disabilities remain predominantly within the health and social development sectors.

In response to the INDS, and in the absence of a national policy prior to the year 2000, the National Department of Health (DoH) formulated the National Rehabilitation Policy (NRP) in 2000. This newly formulated policy is aimed at guiding rehabilitation personnel specifically in service delivery within a rights-based framework. The stated goal of the NRP is to improve accessibility to all rehabilitation services in order to facilitate the realisation of every person with a disability, the constitutional right to have access to health care including rehabilitation services<sup>5</sup>. Improving access to rehabilitation services implies a reorganisation of rehabilitation service delivery from the way that it was organised and delivered previously. Various components of the NRP make reference to decentralisation for improved equity and efficiency in the provision of rehabilitation services, as outlined in *Table 1* on page 23.

### Health Sector Reform – towards a Rights-based framework

The historical and political climate in South Africa have driven social and economic policy reforms to redress past inequities in access to



Table I: NRP content

Policy issue	Data Extract from the NRP
Changing the nature of management	<ul style="list-style-type: none"> <li>• Management of programmes should be decentralized to the provincial and district levels.</li> <li>• Health service managers should be supported in acquiring the skills needed to manage a decentralized health service.</li> </ul>
Planning	<ul style="list-style-type: none"> <li>• Rehabilitation personnel should form part of the Primary Health Care Team.</li> </ul>
Building capacity	<ul style="list-style-type: none"> <li>• Management skills at all levels should be developed if substantive health reform is to be sustained.</li> <li>• Institutional capacity to support human resource planning and management should be developed.</li> </ul>

reforms and policy changes impact directly on the way services are organised and delivered.

### The District Health System and the National Rehabilitation Policy

Within health, decentralisation is embodied in the concept of the District Health System (DHS). The DHS was first introduced as a concept by the World Health Organization (WHO) in 1986 to improve the efficiency, effectiveness and responsiveness of the health system. The DHS is based on Primary Health Care (PHC) and “comprises of a well defined population within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional”<sup>4</sup>. Thus the district becomes the unit of evaluating whether services have reached all those who need it, i.e. coverage of health and rehabilitation services.

The DHS in South Africa is still in its infancy, since receiving a legal thrust through the promulgation of the New Health Act in 2004. The National Department of Health (DoH) started implementing the DHS when the restructuring of Local Government (LG) was

Table II: Levels of Decentralization

Types / Public Administration	Definitions		
	Rondenell <sup>7</sup>	DHS in South Africa <sup>6</sup>	Summary
<b>Deconcentration</b>	Transfer of authority and responsibility from central agencies to field offices of those agencies at a variety of levels (regional, provincial, and local)	Shifting power from the central offices to peripheral offices of the same administrative structure.	Administrative, not political authority – accountable to higher level
<b>Delegation</b>	Transfer of authority and responsibility from central agencies to organisations not directly under the control of those agencies (e.g. semi-autonomous entities, NGO's and regional governments)	Shifting of power and responsibility to separate administrative structures but that are still within the public sector, e.g. to legally incorporated local governments like districts / municipalities.	Clear legal status with a range of functions – Accountable to local electorate
<b>Devolution</b>	Transfer of authority and responsibility from central government agencies to lower-level, autonomous units of government through statutory or constitutional provisions that allocate formal powers and functions	Shifting of responsibility to semi-autonomous 'agencies' which may vary from parastatals, functional development authorities or special project implementation units. They operate free of central government regulations concerning personnel, contracting, budgeting, procurement and other matters.	Management responsibility, outside central government – Accountable to government
<b>Privatization</b>		Some experts view privatisation as a form of decentralisation but others say that it is confusing and inappropriate as it infers a transfer within a particular sector or organisation and not between the public and private sectors. Here the focus is on the contractual relationship between public and private sectors.	Outside government – Accountable to interest groups served

health services. In order to improve service delivery across the public sector, the concept of 'decentralisation' was introduced. These reforms and policy changes are intended to transform the health system towards equity, social justice and improving institutional capacity, thereby meeting the criteria for a rights-based approach. At an operational level these impact on the organisation of service delivery and accountability in the provision of services.

Decentralisation refers to the process whereby authority, functions and resources are transferred from central government to local structures<sup>6</sup>. Literature points to deepening levels of decentralisation as outlined in *Table II*. There are three reasons why decentralisation is pursued. Firstly, for technical reasons, it is pursued for administrative and service delivery effectiveness. Secondly, political decentralisation seeks to increase local participation, autonomy and redistribution. Thirdly, on the financial side, decentralisation is pursued for increasing cost efficiency, accountability and giving local units greater control over resources. These

still in its early stages of transformation. Due to district boundaries still not consolidated, the DoH set up interim structures, which were deconcentrated units of the provincial health department. In 1999, there were 39 health regions and 174 health districts. These remained functional until the district boundaries were finalised by the LG in 2000. Currently, health districts are coterminous with the municipal district boundaries of local government. The changes from interim regions to definite district boundaries, together with the introduction of new communication lines and structures, have a direct impact on the planning and coordination of health and rehabilitation services. Health workers, including rehabilitation professionals were required to continue delivering services within this changing environment.

In the provision of health care services as a distinct function of the overall health system<sup>8</sup>, the policy of decentralisation has resulted in the devolvement of health functions to each province and decentralised hospital management. After the development of the NRP,



each provincial health department was required to use the policy framework and develop further strategic and operational guidelines to facilitate the implementation of the rehabilitation policy<sup>5</sup>. This meant that adequate Human Resource Planning had to take place for rehabilitation services with a review of existing post structures.

The decentralisation of hospitals was aimed at improving facility management, accountability and efficiency through the establishment of hospital superintendents as CEO's. In the planning of human resources, community level posts were created for rehabilitation professionals for the first time in 1996, as part of the PHC team to complement secondary and tertiary levels of care. This was an initiative to change the perception of rehabilitation services from being entirely specialised to an essential service, as stated in the NRP. Since rehabilitation personnel had never been employed at district or clinic level before 1996, this was a new experience for managers, who were required to evaluate and restructure current methods of service delivery, identify the roles of rehabilitation staff at different levels of care and develop an effective referral system.

### Justification for the study

Rehabilitation professionals within the public health sector were subjected to various policy changes at all levels in the last ten years. The NRP, 2000 introduced the concept of 'decentralisation' within pertinent policy issues (as shown in *Table II*). In order for decentralisation to be operationalised, there is a need to review inputs made within the complete and functioning health system with regard to human, financial, informational, and physical resources. Government, through the establishment of the DHS in restructuring the health system and improving equity in access to services therefore is an important agent in the provision of rehabilitation services to people with disabilities. However, challenges within the public health sector have been ongoing and challenges specific to human resources have been well documented and quantified<sup>9</sup>. Qualitative data are needed to understand how rehabilitation staff are coping with policy reforms as there is limited qualitative research on rehabilitation services within the broader health sector.

### Research Objectives

The objectives of the broader study were:

- ❖ To describe how rehabilitation services are managed at primary, secondary and tertiary levels of care within a defined health district.
- ❖ To compare the way these rehabilitation services are managed with policy guidelines and with the existing norms and standards for Occupational Therapy, Physiotherapy, Speech Therapy, Medical Orthotics & Prosthetics and Social Work Professions.
- ❖ To identify and describe the integration challenges experienced by the professionals at operational and managerial levels within a decentralised health system.

### Research methodology

A qualitative research study with a case study design was conducted in an urban district. The specific district was chosen because of the availability of rehabilitation managers at all three levels of care: primary; secondary and tertiary. The target group was ten managers of the rehabilitation services: from the national, provincial, district and facility levels. Sampling was purposeful, where managers were selected specifically for their role in human resource management. Five professional groups as operational staff (Physiotherapy; Occupational Therapy; Speech Therapy; Social Work; Orthotics & Prosthetics) were included in focus group discussions. Twenty four operational staff were invited to the discussions with an equal representation of each professional group, of which 19 attended. These were senior staff who were able to validate what managers were saying and doing.

Data were generated from four sources: key-informant interviews from the managers; focus group discussions from the senior staff; a scoring sheet on observations made at ten sites and document reviews. Document reviews included the NRP; DoH strategic guidelines; various public sector policies impacting on

Human Resources; Professional Norms and Standards as outlined by the Health Professions Council of SA (HPCSA) and the different Professional Associations. A process of inductive analysis was used to understand the experiences, perceptions and challenges from participants through the data generated.

### Findings relating to the experience of providing rehabilitation services within the South African District Health System

This paper presents findings on the third objective relating to decentralisation and the DHS as a health policy reform. Four major themes emerged from the overall data, with sub-themes included to capture the complexity of the data. Only those themes that relate to the DHS are elaborated on. (See *Table III*).

*Table III: Themes and Sub Themes emerging from the data*

Major theme	Sub theme
Predominance of Professional insecurities	<input type="checkbox"/> Trends in resource allocation seen as expressions of the threat to rehabilitation <input type="checkbox"/> <b>Confusion between rehabilitation as an essential service or a specialist service</b>
Service provision or maintaining professional boundaries	<input type="checkbox"/> <b>Lack of awareness of public policies impacting on rehabilitation services</b> <input type="checkbox"/> <b>Differing approaches to improving access and coverage for people with disabilities in service provision</b>
Inadequate teamwork with dysfunctional referral systems	<input type="checkbox"/> Role confusion between the professions and between the levels of care <input type="checkbox"/> Teamwork and coordination: Whose responsibility?
<b>(i) Ineffective management and poor leadership</b>	<input type="checkbox"/> Recruitment and retention of human resources <input type="checkbox"/> Lack of leadership within rehabilitation

#### Confusion between rehabilitation as an essential or a specialised service

The NRP introduces the concept of 'essential' and 'specialised' services although no clear definitions are available. Although there was general awareness of the PHC approach amongst the study participants, professionals working in the hospitals placed greater emphasis on recognising rehabilitation as a specialised service, with reference to the individual, medical approach. Managers as well as operational staff expressed concern at the lack of career-pathing for those rehabilitation professionals who want to specialise, since there are no posts for recognising those who have further qualifications. At the PHC clinics greater coverage was reported because more people with disabilities were able to access rehabilitation services. However, the negative side of this approach was also pointed out by several operational staff, where a loss of 'clinical details' was reported when attempting to reach out to so many clients. Operational staff at the primary levels attempted to define the essential component of rehabilitation service through describing their activities and adopting the social model of disability. However, there was little consensus from their colleagues from the hospitals on the differing roles and responsibilities between essential and specialist services.

#### Lack of awareness of policies impacting on rehabilitation services

The National DoH regarded the NRP as a progressive policy and stated that it helped raise awareness for rehabilitation services (KII 10). The provincial rehabilitation manager reported that the NRP was operationalised, despite difficulties in aligning operational policies to national policies. However, the majority of the partici-





pants at the local facility level, including facility managers, were not aware of the NRP, or the implications of broader changes in health policy. Fourty percent of managers were aware of and had a copy of the policy, but could not relate to its content. Thirty percent of managers were aware of the NRP and conversant with its content. Participants mainly focused on maintaining professional boundaries and on the technical components of their work, by describing the frustrations and obstacles in their efforts to fulfill the professional duties they were trained to carry out.

### Differing approaches to improving access and coverage for people with disabilities in service provision

Various approaches to service provision for rehabilitation were discussed, with the general understanding that services were not reaching many people with disabilities. Participants from the hospital followed the individual, medical approach to service delivery. Some spoke of the group or 'client-based' approach in making the disabled person central to the rehabilitation process, while at the primary level, participants spoke of the concept of Community Based Rehabilitation (CBR) as part of the essential PHC package. However, identifying the most appropriate and effective approach to service provision differed among the participants, especially among managers from the different spheres of government:

Resistance to the concept of CBR as a strategy within the PHC approach was expressed by 90% of the managers. CBR was viewed as an NGO-driven initiative, which was not intended to be

implemented within the formal health system. In addition, training institutions were criticised by the managers for their bias towards professional development, as opposed to service provision and service development. All the operational staff reported that there was limited guidance on service delivery from protocols. Thus, participants are faced with a dilemma between service provision, improving coverage and

*"I think training institutions need to stay in touch with developments, public sector development and I don't think they always do...but making sure that this whole community development aspect is in the curriculum...it is important for them to stay in touch with what happens in the province"*

ensuring access as defined by their employing organisation (being government), and following profession-specific guidelines as defined by their professional associations and the HPCSA.

### Ineffective management and poor leadership within a decentralised health system

It was reported that *"with decentralisation the intention was that managers will be able to manage, but the experience has been different"* (KII: 10). Managers themselves expressed frustration with the system on the whole while staff complained of the frustration of being managed. Participants made direct reference to problems with leadership and human resource issues within rehabilitation and within the health sector more broadly. Overall, it was reported that there was a lack of support in the management and provision of rehabilitation services.

Rehabilitation was not represented on decision-making structures at facility level or within the PHC team, which was dominated by doctors and nurses. While many of these issues were expressed through complaints and frustrations, it was also reported that rehabilitation managers themselves did not address and manage change adequately. Managers needed a *"mind shift but instead were resistant to change"* (KII: 4).

Issues relating to poor leadership and lack of strategic direction were expressed from different perspectives. While change was perceived as a good opportunity to put new structures in place by those in leadership positions, managers in national, provincial and facility (local) levels presented conflicting views and experiences. National managers explained how change is managed by institutional structures that are supportive of goals and objectives and that four to five districts in the province where the research took place, have structures in place. Provincially, there was a call for more leadership posts at district level to initiate services because three reha-

ilitation manager posts were reported to be taken away. The district manager called for an aggressive approach to establish a structure, and added that people are waiting for this structure. Many operational staff reported that existing platforms and structures aimed at facilitating interaction (referring to provincial forums), are ineffective because there is limited time to interact and that the forums are not addressing issues of role clarification.

*"Eventually to finalise a structure that is working for everybody. There is some kind of involvement, but I think there should be an aggressive approach to that. In my opinion, there are people who are waiting for the structures. There is nothing on the positive note to say that they are driving us towards it. You will hear that there is another district hospital coming up. But how are they involving the people who are working there? I don't know."*

The province, seen as the driving force by both the national and local participants, was expected to administer the NRP through developing further guidelines. Facility managers echoed that there was a need for a dynamic leader for rehabilitation at the provincial office stating that generally, indecision and the lack of accountability from provincial health managers, were detrimental to rehabilitation services. The provincial manager felt pressurised between dealing with professional issues, management issues, inter-sectoral issues and the frustrations of general administration hiccups and bureaucracy.

### Discussion

The broader economic, political and social context of health sector reform demonstrates the impact of these factors on the entire health system. While South Africa has met international standards on public policy reforms, challenges in policy implementation are evident in service delivery challenges across the public sector<sup>10</sup>. Implementation of policies depends on effective strategies and programs to translate policies into desired outcomes and practices within the overall system<sup>11</sup>. The experience and performance of rehabilitation managers, as evident from the study conducted, are also reflective of the broader health system<sup>12</sup>.

Confusing priorities and problems with implementation of decentralisation policies define the broader health care environment. Improving administrative and service delivery effectiveness through autonomy and decision-making at more local levels did not result in increased productivity and improved performance for rehabilitation services. Senior rehabilitation managers were challenged by political leaders and activists in the field of disability as stakeholder of the policy reforms to influence the management process directly, but capacity and leadership problems constrained the process.

In terms of institutional capacity, rules and procedures are needed for getting things done and getting them done right for day-to-day functioning in service delivery. Even though the process of policy formulation may be relatively straightforward, it is during implementation that fundamental conflicts between reform policies and the institutional structures and capacity are likely to become apparent<sup>13</sup>. Where 'rules' have not been defined for the provision of rehabilitation as a service, it appears that managers and service providers depended on their own experiences and conceptual understanding of the situation. These experiences in turn, differ from manager to manager and organisation to organisation, thus requiring attention at least on the setting up of rules.

In the provision of rehabilitation services, government has the function of provider of services to the majority of people with disabilities. Therefore, one of the key actors that play a role in setting up these rules for rehabilitation services is the DoH itself, as the agency of government to provide services. Rehabilitation managers employed in the public health sector were not successful in establishing rehabilitation functions within the essential PHC package as prioritized by National Health within the district

<sup>10</sup>Provincial forums are held in the public sector on a regular basis by the provincial rehabilitation manager, to provide a platform for all professionals in the field of rehabilitation to become informed of activities, share information and exchange views.



in question. Evidence from the study demonstrates that the NRP has had little impact on moving away from the individual biomedical approach to rehabilitation, which impacts negatively on access to services and coverage. What was also needed was influencing the way services are firstly conceptualised, and then managed, in changing the structures and responsibilities, as well as addressing allocational inefficiencies in the broader public health sector to make more resources available at primary care levels. Curative care within hospitals, especially at the tertiary level, continues to be better resourced as evident in other research findings<sup>14</sup>.

Rehabilitation managers in the public health sector seem to have been unable to influence change as active participants in the health reform process and have entered the broader debates on effective public service delivery to a limited extent. Management failures within the South African public health system however are not a new phenomenon<sup>15,16,17</sup>. When professional goals are in conflict with the administration of improving access to services (organisational goals), managers are helpless in influencing the institutional context without effective leadership.

## Conclusion

This study concludes that in addition to bureaucratic inefficiencies, additional factors have impacted negatively on the capacity to deliver rehabilitation services and thus on a patients rights to access rehabilitation. These factors are limited awareness of public policies that are framed according to a rights-based approach; lack of direction to operationalise rehabilitation services within the PHC package; differing approaches to service delivery; and lack of clarity on roles and functions between national, provincial and facility levels. These factors have further constrained successful policy implementation.

Building capacity within a decentralised health system following the development of policy is a complex process, which is dependent on effective planning and strategy formulation. The policy of decentralisation and therefore the development of district services was ultimately not a positive experience for rehabilitation managers due to poor management and leadership, lack of adequately defined centralised functions and poor institutional capacity. With evidence of continued challenges in policy implementation at all levels, it is questionable whether the right to access to rehabilitation services for people with disabilities is being achieved. The new ministry established after the 2009 elections to influence policy and improve service delivery inter-sectorally for people with disabilities is faced with the challenge of not becoming another silo-structure within government.

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