# A QUALITATIVE EVALUATION OF INTEGRATION IN A COMMUNITY HEALTH CENTRE

## To determine factors influencing the integration process

Integration of primary health care services is taking place as part of the development of a District Health System. This study was undertaken to determine factors influencing the integration process and to assess the extent to which interventions facilitating the integration of health care personnel in a primary health care centre had been effective.

The focus of the study was on the staff's experiences of the change process and its impact on them and the service delivered, therefore the use of a qualitative method. The results indicated four key areas that had been affected by the intervention, namely: infrastructure and systems; patient care; community participation; and staff interaction. Changes in the external environment and external facilitation of the process were positive contributors. Factors acting as restraining forces were service conditions discrepancies, fear and resistance to change, continuation of existing management structures, and cultural differences between the organisations.

The main findings this study highlighted are that it is critical to deal with the individual fears of people about the perceived and real losses that the change will precipitate. It is important to have external facilitation as it brings a measure of objectivity. Lastly, change needs to happen on multiple levels and behaviour change is made significantly more difficult if it is not supported by changes to conditions and structures as well.

## Introduction

The District Health System (DHS) is a self-contained segment of the National Health System, in which the country is divided into geographically coherent functional health districts. In each district there is a single health service and health management team, with the health system accountable to the elected local government. A single government body is the employer of the health care team, and uniform conditions of service for all health personnel performing equivalent functions prevails. The health team is responsible for the provision of comprehensive health services to the people of the district[1,2].

The development of a DHS must be guided by certain principles. These include an effective strategy to overcome present fragmentation of services, sufficient devolvement of power to the district managers, intersectoral collaboration, and the delivery of comprehensive primary health care services at community level[3,4].

The implementation of the DHS has certain implications. Firstly, the District Health Authority (DHA) needs to be established as the single employer body of all health personnel in the district. The DHA in turn must be governed by some government structure. Several options for the governance of a DHS are proposed, with the new Constitution allotting responsibility for municipal health services to local authorities[5,6,7,8].

Secondly, the DHS has extensive personnel implications. The majority of staff at district level are employed by the provincial authorities. Transfer of staff from one authority to another is legally difficult. There are huge discrepancies between salaries and working conditions for personnel performing similar work for different employers.

Local authorities have traditionally rendered preventive services, whilst the provincial health departments were responsible for mainly curative services. Integration of staff will necessitate a large scale retraining of health personnel[1].

Lastly, financing of the DHS within constrained budgets will be a challenge. New posts are to be generated, management and administrative skills must be developed, and service functions will be broadened. Local authorities contribute funding of district health expenditure to the amount of R290-million per year and the health service cannot afford to lose this[1].

At times of radical change, innovative methods of staff training and development are required to broaden horizons and increase personal confidence. People resist change for many reasons, the most common being misunderstanding, lack of trust, differing assessments of problems and solutions, and low tolerance for change[9,10]. Anxiety about new relationships, fears of the unknown, insecurity about subsequent outcomes and maintaining status are all issues contributing to the problem[11].

One such method is organisational development (OD), defined as a planned process to improve organisational effectiveness through modifications in individual and group behaviour, culture and systems of the organisation, using knowledge and technology of applied behavioural science[12,13]. It is frequently conducted by a consultant or "change agent" trained in the behavioural sciences.

Integration of PHC services was introduced at the Bishop Lavis Community Health Centre (CHC) as part of the development of a DHS in the Cape Metropole[14,15]. OD consultants were used to facilitate the process. The aim of this study was to determine the factors that influenced the staff integration process at the Bishop Lavis CHC and to evaluate the outcome in terms of the initial goals set.

## Method

We decided to use a qualitative method as we faced a whole set of questions about human interaction including issues concerning relationships between health care personnel[16].

Key informants who could provide insight into our problem were identified. In-depth semi-structured interviews were conducted with the informants. Key questions were formulated. The respondents were allowed to make any comments which they regarded as important pertaining to the integration of the service, and the interviews were recorded on audiotape.

The data was analysed by both researchers partially transcribing the interviews independently of each other. Reliability of the data was ascertained by obtaining agreement between the researchers on issues similarly identified during the interviews. Main areas of concern were determined. Validation was achieved by conducting a feedback meeting on the research findings with the staff of the CHC, and assessing their opinion of the findings.

## Results

Eight interviews were recorded and analysed. The respondents were a community representative, a head of department from the university, a senior manager from one of the services, a person on the joint establishment of the service and the university, and four people in managerial positions at the CHC.

The average duration of the interviews was 30 minutes. The following themes were identified as main areas of concern in the integration of the service.

## Infrastructure and systems

Positive changes that were named by the respondents included structural improvements, a unitary filing system and a single

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administration. They however felt that staff from the different services still worked mostly independently, and saw this as a problem that should be addressed.

## Patient care
Several new services were implemented, including a comprehensive mother and child clinic, occupational therapy, nutrition service, and physiotherapy. For the first time a comprehensive primary health care service consisting of promotive, preventive, curative and rehabilitative elements was rendered to the community. Respondents felt that the quality of services also improved, but that the service load increased.

## Community participation
The respondents agreed unanimously that community participation as well as relations with the community had largely improved since integration. It however led to a perception that the community was more demanding than before. The regular meetings with community representatives as well as the presence of a community representative on the premises were seen as contributing to the improved communication between the service and the community. The respondents felt that there was still too little community participation as it was limited to only a few community members.

## Staff interaction
The general feeling was that relations had improved between different groups of staff, although one person felt that they had not improved at all. The regular meetings were regarded as an opportunity to "talk things over", and consultation on a daily basis had improved communication markedly. Changes in staff were seen as having both positive and negative influences. The general feeling was that current relationships and communication could improve. More feedback, team building, conflict management and participatory decision-making were all mechanisms that were proposed to improve staff interaction.

## Changes in external environment
The respondents felt that changes in the external environment to the CHC had a positive influence on the integration process. The importance of a comprehensive PHC policy, the vision of health managers to initiate the project, and the fact that the "time was ripe" for integration were all regarded as having a positive influence.

## External facilitation
External facilitation was perceived to be of value in the process of change. The project co-ordinator from the University of Stellenbosch, as well as the three human resource development consultants from the Old Mutual, were seen to have played a valuable role.

## Service conditions discrepancies
The service conditions are still largely different. This was seen as a contributing factor to the power struggle that people experienced and some of the ongoing issues around co-operation and integration.

## Fear and resistance to change
People mentioned that one of the obstacles to change was the fear of it. People felt threatened by what might be expected of them, of having to operate under different rules, management and systems. They focused on potential loss which made it difficult to see the potential benefits that would result from the changes.

## Continuation of management structure
The fact that the management structures did not change had a negative impact on the change process as it created competition at senior level and a resultant power struggle. The feeling was that a single coordinator should have been appointed whose task it would have been to facilitate the integration of the personnel.

## Culture differences between organisations
Several respondents mentioned that clear culture differences between the organisations were stumbling blocks to integration. Differences included a nurse- versus a doctor-driven service, a preventive versus a curative service orientation, and the staff of one service allowed more autonomy than the other. Fears that any one of the organisations would lose its distinctive characteristics were regularly expressed.

## Discussion
The process of integration in many positive changes, however a number of difficulties arose. The issue of staff interaction was mentioned most frequently. Personnel from different service providers were forced to work closely together as a result of the integration process. The results of this study demonstrated that integration of services causes a whole range of interpersonal interactions, with potential for conflict. The failure to establish the use of a common tearoom became symbolic of the problems to integrate the staff of this CHC.

The reaction and resistance were very typical of what happens to people through a change and transition process. Bridges cites in his work that it is not that people fear and resist change but that it is rather the transition process that induces these reactions as people move from the known to the unknown[17].

In her work on change, Rosabeth Moss Kanter says that the greater the level of participation and communication during the transition and about the changes the easier it is for people to embrace them. They then experience it as something that they are part of rather than something that is being done to them and this sense of ownership and control facilitates the individual's ability to deal with change[18].

Bridges further states that leadership has a critical role to play in facilitating the change and it is vital for them to understand the change process and their role in it if they are to be successful[17].

Changes in the external environment which support the integration of health services are seen as important positive influences. Also, external facilitation of the process is pivotal. It seems to be the relative neutrality of the external facilitators that creates value. They are perceived as more objective with no specific benefits to be gained from the outcomes. One of the difficulties for the external facilitators in the way that this particular process was contracted and undertaken was that they had no influence over implementation. The responsibility was left entirely in the control of the client group. While this is desirable in the long term in the interest of autonomy and self-reliance, the "hands-off" approach perhaps happened too soon as several respondents commented that the process should have been "driven more", and action and outcomes made non-negotiable.

Differences in service conditions were an issue outside the sphere of influence of the people involved in the change process, but had a significant impact on the process as well as the outcomes. It was a fundamental driver of attitude and behaviour, as the staff whose conditions were better perceived that they only had something to lose and therefore were defensive and protectionist. The people whose conditions were poorer on the other hand were resentful and displayed blaming and fault-finding behaviour.

The fact that an imperative to integrate was given but that the structure did not change to demonstrate or facilitate this meant that people were able to largely remain operating as if nothing had happened. The management structure therefore helped perpetuate the sense of "us" and "them", as well as to polarise people further around power bases that would help them maintain the status quo. Systems thinking postulates that every system has a natural tendency to seek homeostasis[19,20]. Therefore if there are pressures for change there are likely to be equal pressures resisting it. Changes in one part of the system will have impacts elsewhere in the system and it is therefore critical that a systemic view be adopted from the conceptualisation phase through to planning and implementation.

The finding on the influence of culture differences on the integration process is perhaps one of the most useful results. Where two separate cultures exist there is often fear from both parties that their culture will become subservient to the other which is perceived to be dominant. This fear results in power struggles to maintain the "own" cultural identity. It indicates to health service planners that a new organisation with a separate culture should be developed, which encompasses the values held by all the organisations involved.