INTEGRATING HEALTH CARE AT THE COMMUNITY LEVEL

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Marietjie de Villiers worked in general practice for ten years before she was appointed to her current position of Senior Family Physician at the Department of Family Medicine and Primary Care at the University of Stellenbosch in 1993.

She is responsible for the full-time MFamMed programme as well as the development of community-based training for undergraduate medical students. Marietjie is the vice-chairperson for the Western Cape branch of the Academy of Family Practice/Primary Care, national council member of the SA Association for Medical Education for the University of Stellenbosch, board member of the Tygerberg-Boland Branch of the Medical Association of South Africa, member of the Community Health Services Organisation Hospital Board and on committees for the organising and co-ordination of CME. Her interest lies in community-oriented primary care, health care for the poor, the integration of primary health care services and medical education – especially community-based education and curriculum development for the training of family physicians in rural areas.

Summary

The comprehensive primary health care approach is a major strategy in providing health for all. The integration of vertical health programmes into a single service at community and district level has therefore become a critical issue.

This has obvious implications for existing fragmented primary health care services at political, administrative and health facility levels. Communities are urged to participate in the planning and provision of their own health services to secure social justice. Also, a diverse mix of health personnel who are oriented towards community-based and multidisciplinary primary health care is necessary to deliver this health service.

This article describes a pilot project which attempts to address these important issues in collaboration with health services, a community and a university. The author outlines the process that was used, notes concerns and offers recommendations. The aim of the article is to provide support to health workers who are currently struggling with issues surrounding the integration of their health services.

Are we different, unique? Is there place for family medicine in the medical school?

This series of articles helps to define where our own brand of medicine lies and what it is that makes family medicine a specialist discipline in its own right.

Is health for all by means of the comprehensive primary health care approach an attainable goal? Are the Alma-Ata resolutions too idealistic to be implemented by most governments? First and foremost we need to know why health improves. Is it the impact of technology on improving lives (especially those of the poor) or is it the influence of macro-economic and development policies of governments[1,2]?

In an effort to reach an answer to these questions, the terms selective primary health care (SPHC) and comprehensive primary health care (CPHC) were coined. The supporters of SPHC argue that, with the effective use of technology, medical interventions aimed at improving the health status of most individuals can be implemented at the lowest cost.

CPHC on the other hand, is concerned with the processes of development through which communities can take ownership of their health and can improve both their lives and lifestyles. SPHC relies on vertical programmes that seek quick technical solutions to health in contrast to CPHC which supports integrated programmes which address a wide range of development issues in the longer term[3,4].

South African health planners have pledged their support to the CPHC approach[5]. Fragmented health services and vertical health programmes should be integrated into the single delivery of primary health care services to a community. This should take place at the community health centre. It is, however, not an easy task to convince health professionals that their vertical programmes (with their short-term dramatic effects) should be replaced by a blanket of (perceived) diluted skills and services.

Also, if we are serious about CPHC and its long term effects, we will need considerable political will, the expansion and upgrading of existing health infrastructure at the community level, and most importantly, an attitude change from our health service workers and managers[6].

Throughout South Africa at least 71 000 people are employed full time in the public sector to provide community and district level health services. About 63 000 (89%) are

employed by provincial administrations, while the remaining 8 000 (11%) are employed by 407 different local authorities. Many discrepancies exist between salaries and conditions of service of health workers employed by separate authorities[7]. Informal integration of services is launched in many facilities, involving primary health care personnel in extremely sensitive issues around the practical integration of staff at the district and community level[8,9].

Efforts are directed to overcome organisational and administrative fragmentation caused by regional, district and health authority boundaries.

Consultation phase

The Department of Family Medicine and Primary Care at the University of Stellenbosch was in need of appropriate, community-based training facilities for family physicians. A symposium to explore this idea was convened in 1991. A particular need for the establishment of a model for an "ideal" community health centre providing comprehensive primary health care services was expressed at the symposium. This extended the original goal of establishing a community-based training facility to include the integration of health services at community level with meaningful community participation in the process.

A committee was appointed to formulate a plan for the implementation of these aims. This committee surveyed several areas and subsequently selected the Bishop Lavis area for the project.

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Description of Bishop Lavis health services in 1991

Bishop Lavis is a peri-urban community of approximately 40 000 people and is situated on the Cape Flats. The community is mainly Afrikaans-speaking, so-called "coloured" people, with a mean income of R400 per month (1991 census). At that stage the health services were completely fragmented. Curative services were rendered by the former Department of Health and Welfare (House of Representatives), with ante-natal and maternity services managed independently in the same complex by Tygerberg Hospital.

Promotive and preventive services were supplied by the Health Department of the former Western Cape Regional Services Council (WCRSC) in a nearby building.

No rehabilitation services were available.

Second consultation

A second consultation meeting was held in March 1992 when a steering committee was nominated to manage the process. This committee consisted of health service managers from separate health authorities, representatives from different staff components, university staff and community members.

Planning phase

The steering committee formed three working groups, each responsible for (a) the integration of services, (b) training needs, and (c) community participation.

They engaged in extensive planning from April 1992 until August 1993. This planning process entailed numerous meetings, extended periods of negotiation, several setbacks, and generally a great deal of work for all involved. The Department of Health and Welfare (House of Representatives) allocated money for the project. This financed the transfer of the clinic services to the main building, equipment for the new rehabilitation centre and the creation of new posts for a physiotherapist, an occupational therapist, a dietitian and a family physician.

Implementation phase

(a) Integration of services

Various services were moved during 1993, resulting in the clinic, day hospital and maternity unit all operating from the same building. A rehabilitation centre was established in the building previously utilised by the clinic. New services included physiotherapy, occupational therapy, dietetics, and family medicine.

The rehabilitation centre established a wide range of innovative services including home visits, exercise classes, activities at the old-age home, work assessment, support groups for the disabled, evaluation of children with learning problems, training of care givers and voluntary workers, and treating individual clients.

The dietitian introduced a new dimension to the service with an emphasis on health education, breast feeding promotion and support, group education for patients with chronic diseases of lifestyle, evaluation of malnourished children and counselling patients on an individual basis.

An important feature of this phase was the establishment of a comprehensive mother-and-child health service. This service was provided by the primary health care nurse practitioners at the clinic. The principles and practice of community-orientated primary care were introduced by the family physician.

(b) Training needs

The creation of the new posts facilitated

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community-based training of students in human nutrition, occupational therapy, physiotherapy, family medicine, basic and post-basic nursing as from January 1994. Lecturers from the university supervise the training of these students[10].

The formation of the community health committee was a long and difficult process and a personal invitation had to be extended to role-players for a meaningful meeting to be held.

(c) Community participation

The formation of the Community Health Committee was a long and difficult process. The planning committee's initial strategy was to call on the community to attend meetings. Unfortunately the attendance at several meetings was very poor. "Waiting room" meetings were then held to elicit the problems that the community was experiencing.

This, however, did not succeed in attracting the real community leaders. Eventually the steering committee employed a well-known member of the community for a period of time. Her task was to compile a list of all community organisations, to visit each individually and to extend a personal invitation to role players to attend a meeting. In July 1993 the first meaningful meeting was held and representatives from many organisations were nominated to serve on the committee.

Ongoing development

By January 1994 most of the original aims of the project were realised. There was a comprehensive primary health care service delivered by a multi-disciplinary team from a single facility. Many students were rotating through the Community Health Centre for community-based training. A representative community health committee was in place.

Integration however meant more to the staff than that. The idea was that elements of the service could be more closely integrated and that staff from different authorities could work together and share in each other's tasks. This implicated major organisational changes in the Community Health Centre which would need professional guidance.

Efforts to consolidate and integrate different services and staff components encountered serious conflict and disagreement before some resolution could occur.

Old Mutual was approached and human resource consultants agreed to engage in a process to manage the change. The process included an assessment of the concerns of the staff about the integration process, planning workshops with the steering committee, team building workshops for the staff, strategic planning workshops with key staff members and workshops with the community health committee to support the development of the committee.

The outcome of all these measures was dramatic at first. Staff felt more motivated towards integration and less animosity was experienced between different staff complements. The reception areas were combined into one area. The record systems were integrated so that a single record was in place for each patient. The day hospital pharmacy supplied medicine for the comprehensive mother-and-child health service at the clinic.

A single telephone and intercom system was installed. Regular weekly management meetings were held with portfolio managers from the centre. The community health committee's monthly meetings were well attended, fund raising aggrandised and projects were planned and implemented. A community survey using a participative research method was conducted to assess the problems of the community.

Voluntary workers from the community came forward for training and to show their support for the service. Staff were interchanged including doctors, nurse practitioners and cleaning staff. Other vertical programmes also joined the integration process at the Community Health Centre namely mental health, school health, oral health and social work.

Concerns

Efforts to consolidate and integrate different services and staff components encountered serious conflict and disagreement before some resolution could occur.

Differing conditions of service and the continuing existence of separate administrative and managerial structures were major stumbling blocks.

Different conditions of service cause distrust and jealousy and discourage staff to perform duties outside of their service contract. The process to write job descriptions for the nursing staff that would include both preventive and curative functions never progressed. In the absence of the integration of top management, the lack of a corporate mission remained.

Management is perceived to be unfair in expecting staff to integrate whilst management themselves fail to do the same.

The organisational development process ground to a halt when a decision was taken (by the staff) that a co-ordinator should be chosen for the centre. The differences in cultures between the organisations (nurse-driven service versus doctor-driven service) prohibited a single person to be in charge of the integrated service. The staff also blamed a large service load for the slowing down of the process.

Community participation has waned over the years. In conjunction with other experiences we, however, recognise that community participation in health by disadvantaged communities is a learning process[11,12]. Factors that play a role in the sustainability of community participation are the status of the committee, the profile of the role and projects of the committee in the community, the perceptions of representatives that they have no real power through these committees, the many commitments of a handful of dedicated community representatives, political in-fighting in the community, and the fact that there is no remuneration for a job that could be time consuming.

Recommendations

1. The process of integrating health care at the community level must be fully participative at all levels from the start. Although this implies a cumbersome and slow process, all role players must take part in the planning.
2. Management largely influences the opinions and actions of their employees. Therefore, managers of different employer bodies must be officially and visibly committed to the integration process. They should also not be seen as "taking sides".
3. A neutral person to serve as facilitator is crucial. Such a person should have credibility with all staff members and must be regarded as impartial by them. The appointment of an independent Community Health Centre manager is a logical solution.
4. Community participation throughout the process is very important. The sustainability of community participation must however be encouraged by measures to empower these committees.
5. Clear aims must be formulated. The aims should be revised regularly and goal-posts should be shifted where necessary.
6. Consensus should be reached on what is meant by the integration of health care. Integration means different things to different people. Each centre should be granted the opportunity to decide to which level they can integrate staff and services.

Conclusion

Integration of health services at community level remains a daunting but challenging task. It is still perhaps one of the few viable options to the even marginal achievement of health for all. Careful planning, negotiation and collaboration of all probable and improbable stakeholders are crucial tasks.

The Bishop Lavis Primary Health Care Project emphasises the advantages but also the difficulties encountered in the integration of primary health care services. Whilst the project has achieved the integration of a host of vertical health programmes into one facility, we have failed to implement the ultimate goal of full functional integration of all staff. Should this goal not then perhaps be the integration of services up to a level that is attainable for a particular Community Health Centre?

Factors external to Community Health Centres need to change in order to facilitate integration. A decision on the governance of the district health system needs to be taken. This decision should consider accountability to district as well as to higher authority, community participation in decision making and internal management of the district.

The complexity of management structures must be reduced and power devolved to the Community Health Centres[13]. All public health services should be the responsibility of one administration and nursing, medical, administrative and support personnel line functions should be assimilated into a single management hierarchy[14].

We need commitment and support from national, provincial and local authorities, control over financial and personnel resources and authority over decision making at the Community Health Centre level[15]. The longer management is grappling with the issues, the more discouraged the staff becomes. We need a clear message on the way ahead regarding the integration of our primary health care services.

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