PHC & transformation of health sector

National Education Health and Allied Workers Union (Nehawu) welcomes the Primary Health Care (PHC) approach as outlined in the Green Paper, but argues for better hospital management, improved human resources policies, and training of more health-care professionals.

The proposed re-engineering of PHC with the introduction of Family Health Teams and the incorporation of Community Health Workers (CHWs) into the health system are important steps in implementing the PHC approach. However, for Nehawu the adoption of the PHC has deeper implications in transforming the health sector.

PHC aims to provide access to good quality care and prevention, promotion and rehabilitation services as well as improved living conditions for priority health needs. Health is viewed as a basic human right and a worldwide social goal – based on principles of solidarity and collective values, equity and social justice.

In PHC health should be sustainable, developmental and meant for all sections of society at the local level. This way it is able to address the root causes of ill-health and to promote local accountability through enhanced community participation.

People are involved as active participants with both rights and duties to participate and not as 'clients' or 'consumers'.

Inter-sectoral collaboration and action are key aspects of the PHC because living conditions – without running water, toilets, healthy food, decent housing, proper schools and playing spaces for children are recognised as the major cause of diseases and poor health.

Nehawu believes that the case for focusing on PHC in South Africa now is compelling for the following reasons:

1. There is widespread global evidence that PHC is effective and makes sense. In addition there are case studies from a number of countries (e.g. Brazil and Thailand) with a long history of implementing PHC and with associated dramatic improvement of health outcomes.
2. South Africa has poor outcome indicators relative to the amount of resources that are being spent in the health sector compared to most middle- income countries. Much of this is due to the overwhelming impact of the HIV pandemic, which itself requires a PHC approach.
3. PHC interventions assure greater equity compared with higher levels of care, primary-care services are more geographically, financially, and culturally accessible to local communities. They also provide more personalised care to the poor people who need it most.
4. PHC services can handle a wide range of basic health conditions. These services are usually located in communities, making them the first point of contact with the health system for many individuals and are planned to reach out to marginalised and underserved groups. Such groups might not otherwise seek or receive health care and specialised care when needed.
5. PHC interventions reduce the disease burden by effectively addressing the most common health needs of children and can bring the greatest benefits to the health of families and communities. This improvement in the status of family health can reduce the possibility of catastrophic economic consequences resulting from serious ill-health.
6. With access to these services within the National Health Insurance (NHI) being via a

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The training of more nurses is important for primary health care

clinic or community health centre where these services are expected to be nurse-driven, the same services can more easily be made available throughout the country – in rural and urban areas.

INSTITUTIONAL TRANSFORMATION

Nehawu maintains that the management of hospitals is a critical aspect of the operations of a hospital. Over a period of five years starting in 2003 as a Nehawu / Naledi (Research Institute attached to Cosatu) initiative at Chris Hani Baragwanath Academic Hospital, a team of clinicians, nurses, administrators, trade unionists and expert consultants implemented a pilot project for transforming the functioning of hospitals in the surgical division.

The unique project systematically constructed a new model based on the principles of decentralisation, integrated management and clinical leadership with an important role played by trade unions. The model was designed to improve patient care, management efficiency, and staff satisfaction and morale, and made significant progress in these areas through empowering staff and managers.

The integration of clinical and administrative functions into a single management team led to establishing order, coherence and stability in the division. Routines both in clinical practices as well as in support functions were established so that decisions were based on consistent and reliable information and the ready availability of the material and human resources.

This decision-making ensured that the interface between the daily work practices and the public in the form of the patient took precedence over, and shaped everything else.

While the new model is appropriate in terms of the structure of the labour process, it is also extremely powerful as a solution to the dire shortage of management expertise and skill in South Africa. It makes use of the considerable clinical skills that reside in doctors and nurses that still exists in the public health sector.

Nehawu argues that this model, while constructed specifically to improve patient care outcomes in a tertiary academic hospital, can be tried across the public health-care system in secondary and district hospitals, community health centres and clinics. However, this depends on the context of the health centre.

HUMAN RESOURCES

While it is encouraging to see the inclusion of a strong focus on primary health care and the designation of hospitals in the Green Paper, it is of concern that there is little mention of human resource strategies. It is understandable that the recently released Human Resource of Health strategy document would reflect far greater detail. However, reference to human resources related to the NHI would have been welcomed in the Green Paper.

Two of the major barriers to the implementation of an NHI are the lack of professional and support personnel and the conditions under which they work.

Nehawu argues that a number of measures will have to be introduced to ensure that the public sector can become the provider of choice for South Africans.

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Nurses display their support of Nehawu.

VACANT POSTS AND STAFF

The two central requirements for retaining staff are appropriate pay scales and working conditions.

There are many vacancies in the public sector. As an example, according to the personnel administration system, in 2008:

- 34.9% medical practitioner positions remained vacant in the public sector
- 40.3% of professional nurse positions were vacant.

The extent of the vacant and unfunded posts for professional categories and for support staff has a major impact on the morale of staff and the quality of service delivery.

Nehawu believes that the importance and value of support staff cannot be over-emphasised. The workload of professionals increases significantly when posts for support staff are left vacant thereby forcing professionals to undertake administrative work as well contributing to burnout.

The impact of vacancies is particularly significant in rural areas. Suggestions for improving the understaffing over all categories of health worker including mid-level workers in rural areas are:

- employment of sufficient health workers for adequate cover as well as time off work;
- application of a rural quota for student intake – not only a racial quota;
- bursaries could be provided for students from rural areas on condition that they return to these areas once studies are completed;
- clinical support and governance should be improved to include rotating specialist visits and senior medical officers;
- information and support provided around logistical issues such as accommodation, schools for children.

The poor condition of many of the facilities – in large partly due to the reduced budgets for health from 1998 to 2006 – is often cited as one of the reasons for the inappropriate attitudes of health workers. Infrastructure and amenities including accommodation for rural health workers should be upgraded, maintained and replaced through the use of departmental budgets or funding from development institutions and not through public private partnerships with private-sector companies.

RESTRUCTURING HEALTH TEAMS

Good work has been undertaken by the Department of Health on primary care level, which promotes the introduction of family health teams and the formalisation of the role of community health workers.

Restructuring of the health teams must be extended to all levels of the health services and will need to be undertaken particularly to ensure the inclusion and formalisation of the roles of mid-level workers to include placing them at primary, regional and tertiary levels of care.

The shifting of certain specific tasks from doctors to nurses, from health professionals to mid-level workers and community-based workers will provide better quality care at primary and secondary levels, especially in understaffed rural facilities, and will reduce costs. In order to accomplish the task shifting successfully, standardised training based on the South African Qualifications Authority-based qualifications must be introduced and both mid-level workers and community health workers will need to be regulated more effectively.

Of concern is that if the national department does not take the lead and provide the strategy for the full integration of CHWs into the public service, we could end up with nine different variations. Already two provinces (KwaZulu-Natal and Gauteng) have begun to take responsibility for the payment of stipends to CHWs and are using different mechanisms with other provinces still discussing.

A further concern is that the effectiveness of the formal introduction of CHWs into the

system could be compromised in the rural areas due to the travelling distances between households and clinics.

MORE HEALTH PROFESSIONALS

More health professionals will have to be produced for the public sector to become the provider of choice. Increasing the urgency is the probability that within the next 10 years 40% of current nurses could retire. Universities have been requested to increase the output of medical students and new health sciences faculties will come on stream.

However, much of the routine work which is done by doctors can be done by clinical associates who are currently being trained at three universities. This should be extended.

For nurses, it is pleasing to note the progress in the Department of Health with regards to the opening of nursing colleges that were closed in the 1990s and 2000s. It is important that the three-year diploma must be re-instated and enrolled nurses be able to enter second year to increase the pool of professional nurses at a faster rate.

Until such time as training institutions in South Africa are able to deliver the quantity of health professionals required, the state should investigate the importing of health professionals from overseas as well as the registration of foreign nationals from the region who have become exiles in South Africa.

OUTSOURCING

Outsourcing of services has had a negative impact, for example on cleaning, laundry, catering and security services. Outsourcing does affect the quality of the service delivery itself as the quality of the work of outsourced workers is never the same as people who get to know patients and who work consistently in a committed team with other staff.

Infection control in health facilities has been compromised through lack of commitment of cleaning and catering workers from outsourced companies and the security of health workers has been hampered by the outsourcing of the security function.

The conclusion and roll out of an effective remuneration policy will remove the need of nursing agencies in the public sector and put an end to moonlighting of public sector nurses in the private sector. Moonlighting often means that these nurses are then unable to perform their duty in the public service adequately.

Whilst Nehawu is in agreement with the principles of the NHI document, it seems that there has been an omission of public administration. This links to the comment in the document in section 132 in which it is stated that a multi-payer system will 'be explored as an alternative to the preferred single provider'.

A further point to mention is that facilitating transport to health services, particularly for rural communities, is an essential requirement to establish a health system based on universal coverage and to address one of the barriers to accessing health-care services.

HEALTH-CARE BENEFITS

The Green Paper discusses the benefit package in very general terms indicating the intention to make the benefit package comprehensive and rational.

The ANC policy document is more specific about a benefits package indicating that 'the NHI Fund will provide an evidenced-based comprehensive package of health services, which includes all levels of care, namely: primary, secondary, and tertiary... The services to be provided to the public cannot be less than what they are currently receiving.'

Further clarification in the ANC policy document indicates that the package should include:

- primary care and preventive services;
- inpatient care;
- outpatient care;
- emergency care;
- prescription drugs;
- appropriate technologies for diagnosis and treatment;
- rehabilitation;
- mental health services;
- the full scope of dental services (other than cosmetic dentistry);
- substance abuse treatment services.

It is gratifying to note that in section 11.2, which deals with the delivery of primary health-care services through private providers, there is a requirement that the full range of primary care services must either be available in one facility or through arrangements that do not disadvantage the patient in any way.

The benefit package must be spelt out in the same terms as in the ANC policy document and it must be clearly stated that the same benefit package will apply for both public and private sectors. LB

This article comes from Nehawu's submission on the National Health Insurance (NHI) Green Paper. It is the second part of a three-part series.