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Primary care in South Africa

Reflections on conceptualisation and a review of the recent literature

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Abstract **This paper reviews the various interpretations and connotations of the term 'primary care' as employed in South African literature and practice. There is a need for clear definitions of key concepts and the utility of the primary care framework proposed by Barbara Starfield is suggested in this regard. The paper also reviews and evaluates the research on primary care in South Africa published since 1988.**

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This paper explores the various definitions of the term 'primary care' and reviews the Medline-referenced literature for the period January 1988 to August 1991 and the relevant articles in the *SAMJ* from August to November 1991 to illustrate both what we know and what we do not about primary care in South Africa.

Given the various calls for a new national health policy,[1] it would appear that a focus on health services research is appropriate. It is essential that health policy analysts examine the successes and failures of past and current health policies in South Africa and base future policies on rigorous research. Future policies must have an evaluative component built into them, as policy development is an iterative process. This research depends on an adequate theoretical framework and precise definitions. This paper will attempt to illustrate this in terms of one level of health care, i.e. primary care.

Primary care

The context

In South Africa there has been a growing interest in challenging the dominant health education and delivery systems and the practices of providers with regard to the context of health care, i.e. racial capitalism. To this end various health organisations (e.g. the National Medical and Dental Association, the South African Health Workers' Congress, the Organisation for Appropriate Social Services in South Africa and the National Progressive Primary Health Care Network) were formed during the 1980s as alternatives to the 'official' professional bodies, to mobilise particular health provider constituencies to: (*i*) investigate and publicise the effect of apartheid and capitalism on health and health delivery; and (*ii*) challenge the state to make political changes that would prevent any deleterious effects of the socio-economic/political system on health.

Contested terminology

It is generally agreed that primary care has the following features: longitudinality, co-ordination, comprehensiveness, accessibility and accountability.[2] While this description predates the Alma Ata conference, it was this conference that put primary care on the 'health agenda'.

South Africa was not unaffected by the momentous Alma Ata conference, even though it was not represented there. The rhetoric of Alma Ata soon appeared in the health legislation, e.g. the 1980 National Plan for Health Services Facilities, which documented a plan to shift an emphasis from secondary and tertiary care to primary care. However, a state-appointed commission of inquiry into health services which reported its findings in 1986 found that too much money was being spent on tertiary care and too little on primary care (6 years after an ostensible policy change); it also suggested that rather than more hospital beds, more primary care facilities should be established.[3]

Many reasons for this can be suggested. Jinabhai[4] argued that an alliance of the medical establishment (including medical schools), the multinational pharmaceutical companies and medical suppliers effectively subverted the possible shift of emphasis from tertiary to primary care. Coovadia,[5] however, appears to blame the State for the lack of movement. He suggests that the State re-interpreted the Alma Ata vision of primary health care, reducing it to a technical intervention that sanitised its revolutionary elements.

A further reason for the failure of the State's initiative is the distrust between the State and most communities (especially black communities). Apparently in response to these perceptions the progressive health sector relabelled the process 'progressive primary health care' in an attempt to differentiate it from the State's initiative.[6]

In the South African literature both the concepts 'primary health care' and 'progressive primary health care' embody the broad principles of the Alma Ata declaration. However, there are differences which include: (*i*) the level and type of community participation — while the former tried to make primary health care structures accountable to the largely discredited local community councils, the latter facilitated the election of popular health committees; and (*ii*) the extent to which health was 'politicised' — the latter defined health in terms of the political economy, e.g. by linking health status/provision of services to apartheid and capitalism.

Progressive health organisations and providers seem highly sceptical with regard to the State's initiatives (even though, or maybe because, there has been little change in the provision of primary care). These progressive organisations have initiated projects in both urban and rural areas in an effort to: (*i*) provide health resources in underserved areas; and (*ii*) implement their notions of progressive primary health care.

The term primary care is not used in the South African discourse. Starfield[2] provides the following definition: 'It is the basic level of care provided equally to everyone. It addresses the most common problems in the community by providing preventive, curative and rehabilitative services to maximise health and well-being.' This definition is especially important in the South African context, given the State's insistence on a larger role for the private sector in the provision of health services and the lack of a national health strategy that has the support of the majority of its citizens.

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Starfield[2] lists the following key ingredients of primary care:

First contact. This refers to accessibility and use of services for each new health issue or episode for which care is sought; the definition implies a role for the consumer in identifying a particular facility as one that provides first-contact care.

Longitudinality. This refers to a regular source of care and its use over time; the potential utility of this definition is that it allows the provider to define his population.

Comprehensiveness. This refers to the health services offered, and while it is acknowledged that each primary care facility can decide on the package of services that it will provide, it should also be willing and able to arrange other types of health services required, e.g. referral to secondary or tertiary hospitals, social welfare services.

Co-ordination. This refers to continuity of care especially if the consumer is either referred to other providers or cannot be seen by the same primary care provider on each visit, e.g. in a hospital outpatient department. The need for an efficient and adequate information management system (with feedback loops to referral source) is vital for proper co-ordination.

Accountability. This aspect of primary care is least emphasised by Starfield but is an important feature of the Alma Ata declaration, which noted the need for health providers to be accountable to the community they serve.

The providers of primary care

In South Africa, primary care is provided by the following health providers: general practitioners (GPs) in private practice, local clinics (staffed by nurses and possibly a GP), and the outpatient departments of both secondary and tertiary hospitals.

In 1987 the doctor/population ratio varied from the national average of 1:2 320 to 1:40 000 in the rural areas (where approximately 50% of the population live). During the same period there were 1,4 nurses per 1 000 population in the 'homelands' while there were 6,8 nurses per 1 000 population in the major cities.[7] Of the physicians, 14 355 were GPs and 4 245 were specialists.[8]

The importance of both nurses and GPs to primary care is illustrated by Buch,[7] who suggests that the clinics, in both urban and rural areas, provide the bulk of the primary health care for working-class South Africans whereas the GPs who provide health care on a fee-for-service basis do the same for the middle classes (who generally have private medical insurance).

The current role of the GP in the provision of primary health care is not uncontroversial. IJsselmuiden,[9] in reporting on a workshop attended by both community representatives and health providers, suggested that the role of the GP was unsatisfactory for the following reasons: (*i*) GPs were inefficient and costly; (*ii*) GPs had little interest in educating others to assist with primary health care; and (*iii*) they were under too much pressure to provide adequate care.

Review of the literature

The following key words and phrases were used to locate relevant publications: primary health care, primary care, GPs and family practice.

During the period reviewed (1988 - 1991) 20 articles appeared that reflected on primary health care in some way. Seventeen of these appeared in the *SAMJ*, 2 in *Social Science and Medicine* and 1 in the *International Journal of Epidemiology*. Given that the majority of articles were found in the *SAMJ*, a separate survey of the journal for the period August 1991 to November 1991 was conducted. This revealed the existence of another 4 articles.

Some of the major themes reflected in the literature included: (*i*) the need for more primary health care (and specifically lower level providers, e.g. medical auxiliaries and village health workers); (*ii*) utilisation patterns of hospital outpatient departments; (*iii*) co-ordination of care as reflected in referral patterns; (*iv*) the development of health information systems for primary health care centres; (*v*) evaluation of primary health care centres; and (*vi*) the potential of existing local state-run health services in the provision of primary health care.

It may be useful to categorise the publications in terms of Donabedian's three components, i.e. structure, process and outcome.[2] Structure entails the physical and social arrangements that constitute health service delivery, process refers to the day-to-day provider-patient relationships, and outcome refers to the health status changes in the patient.

The articles that suggest the need for more health providers and the re-structuring of health care services deal with structure; those that researched the co-ordination of care fall under process. There appears to be a lack of research into outcome. Additionally, there is a dearth of literature on the practice patterns of the large number of GPs in private practice.

Appropriateness of care

In a study of the level of care required by inpatients, Bachmann *et al.*[10] found that about 50% of inpatients could have been adequately treated in other settings while a smaller percentage could have been treated in an ambulatory setting. They do not state what proportion of these could have been treated in a primary care setting.

In another study (also at a tertiary care hospital) Rutkove *et al.*[11] found that 42,2% of the patients attending the paediatric outpatient department for the first time, of which the majority were unreferred, were there unnecessarily. These patients could have been treated more appropriately at primary health care level.

First contact

Henley *et al.*[12] found that a large tertiary hospital served as a facility of first contact for a significant number of patients. Thirty-eight per cent of the medical ward patients had sought care without a referral letter from a primary care provider. This was an improvement on the figures for 1985, when 60% of the patients were self-referred.[13] At another tertiary hospital Rutkove *et al.*[11] found an even higher percentage (78,5%) of unreferred patients.

In a community-based study of child health and health care utilisation, Lachman and Zwarenstein[14] found that 50% of first-contact care was provided by GPs in private practice. The public sector was the source of care for those with the most severe acute and chronic illnesses. Choice of private or public care was determined by whether or not the patient had private medical insurance coverage and the time of day that care was needed. Since all the public clinics were closed at night and over the weekends, children in need of care during these times had to depend on the private GP (if they could afford it) or wait for the public sector clinic to reopen.

Barriers to access have been identified by Soderland *et al.*[15] They found that the aged (average age 71 years) in two rural communities failed to seek care because of high transport costs and the unavailability of care. The closest clinics to these communities were 6 and 12 km away respectively; the closest hospitals were 35 and 45 km away.

Co-ordination

In their investigation of response to the referral source, Lachman and Stander[13] found that only 30,3% of all staff replied to the referral source. Of those who did reply, consultants (66,7%) and technicians (72,7%) were the most responsive.

A further example of lack of co-ordination between rural clinics and the regional referral hospitals was reported by Lee *et al.*[16] (More information is provided below.)

Health information system for primary health care

Ferrinho *et al.*[17] reported on the development of a health information system used in a peri-urban primary health care centre. They suggest various uses for data: (*i*) strategic planning and development; (*ii*) health indicators to identify patients particularly 'at risk' and chronic populations; and (*iii*) to assess 'missed opportunities for preventive and promotive care'. They identified three key categories of personnel crucial to the successful implementation of their information system, the success of which depended partly on the extent to which they 'owned' the system. These included the centre manager, the system officer and the health care workers responsible for collecting data.

Evaluation of primary health care facilities

One study reported on an evaluation of a series of 15 rural primary health care clinics in one district. Nurses provide weekly sessions of care to under-5-year-olds, antenatal care, chronic disease care and obstetric care; a GP/medical officer visits once a month.[16] These clinics are part of the health care system of one of the 'homelands' and are public facilities. The study investigated the adequacy of 'support systems, facilities and staffing and community involvement'.

Coping with unmet health care needs

A number of articles focus on the significant percentage of health care needs that go unmet.[15,16,18,19] This is especially true of the overburdened public sector which serves the majority of the population.

To improve obstetric care in rural communities Larsen[18] argues, *inter alia*, for the training of village health workers and traditional birth attendants. He also suggests the need for more professional support for the rural GP.

Whittaker[19] argues that the 900 medical graduates that South African medical schools produce each year are not sufficient to meet the population's health care needs. Support for this is cited in Keet *et al.*[3] It is estimated that South Africa needs an additional 800 medical practitioners per year to maintain the current average doctor/population ratio (and to achieve a better distribution). Given the impossible financial burden and the large numbers of patients who are seen, inappropriately, in tertiary care settings, Whittaker's argument for the training of medical auxiliaries appears sensible — especially to carry some of the primary health care load.

Conclusions: potential research issues

This limited survey of the literature indicates a few potential research issues in terms of the criteria that describe primary care. It is also apparent that GPs in private practice are consulted by a significant number of patients.[13] This has not been the subject of recent research. Also, the literature search suggests that no research on the patterns of practice of physicians working in outpatient departments of secondary care hospitals (local and community hospitals) was published in the period under review.

It is apparent from the literature that we know very little about issues of longitudinality, continuity, comprehensiveness, accessibility and accountability as they pertain to primary care.

It may be useful for health services researchers to focus on all three components of the health care system. This requires, in the jargon of evaluation research: (*i*) process evaluation, which evaluates the strengths and weaknesses of the day-to-day operations and searches for ways to improve the process; and (*ii*) outcome evaluation, which evaluates to what extent the desired patient outcomes are being achieved and can be attained with improvements in the structure and process of health service provision.

It is also argued that primary care, as defined by Starfield,[2] can be a catalyst for more rigorous research into the role of GPs and nurses in South Africa.

The state should be encouraged to follow the World Health Organisation/United Nations Children's Fund Conference guidelines which recommended that every national programme budget for continuing health services research (with feedback loops to the providers so that practice patterns can be transformed if necessary). This issue emphasises the need for a national health plan that is widely debated before adoption and enjoys widespread community support.

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