

# An analysis of the meaning of integrated Primary Health Care from the KwaZulu-Natal Primary Health Care context

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## **Key words**

Primary Health Care; Integrated Primary Health Care; grounded theory

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In South Africa, integration of services policy was enacted in 1996 with the aim of increasing health service utilization by increasing accessibility and availability of all health care services at Primary Health Care (PHC) level. Integration of PHC services continues to be seen as a pivotal strategy towards the achievement of the national goals of transformation of health services, and the attainment of a comprehensive and seamless public health system. Although the drive behind the integration of PHC services was to improve accessibility of services to the community, the problem however, arises in the implementation of integrated PHC (IPHC) as there is no agreed upon understanding of what this phenomenon means in the South African context. To date no research studies have been reported on the meaning of the integration of PHC services. Hence, there is a need for shared views on this phenomenon in order to facilitate an effective implementation of this approach.

A cross-sectional study, using a qualitative approach was employed in this study in order to analyze the phenomenon, IPHC in KwaZulu-Natal and the meaning attached to it in different levels of the health system. A grounded theory was selected as it is a method known for its ability to make greatest contribution in areas where little research has been done and when new viewpoints are needed to describe the familiar phenomenon that is not clearly understood. Policy makers and co-ordinators of PHC at national, provincial and district levels as well as PHC nurses at functional level participated in the study. The data was collected by means of observations, interviews and document analysis. The sample size for interviews was comprised of 38 participants. Strauss and Corbin's process of data analysis was used. It emerged that there were three core categories that were used by the participants as discriminatory dimensions of IPHC in South Africa. These core categories were (a) comprehensive health care, (b) supermarket approach and (c) one stop shop.

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## Background to the study

The redirection of the health care system towards Primary Health Care (PHC) along with the concomitant establishment of the District Health System (DHS) as a framework for PHC delivery and management has been the transformation event in the public health sphere in South Africa since 1994. One of the foremost changes in the early years of the democratic government was the adoption of a district-based system, which is the principal instrument for the delivery of comprehensive integrated PHC services, in line with the Declaration of Alma Ata. The goal of the DHS was to achieve equity and improve access, effectiveness and efficiency of services through decentralized management services and localized service provision (Harrison, 1997: 4). As equity and access to health care have since 1994 been considered the key principle to steer the transformation of health services in South Africa, a mechanism was required to define parameters for service delivery, as well as to ensure comparability in the rendering of services. This mechanism was realized in the form comprehensive PHC service package that was introduced by the National Department of Health in 2001. According to this package, integration of PHC services (IPHC) in South Africa was put in place so as to address the problem of shortage of staff and limited resources in PHC setting. Whereas in the past, the model of PHC delivery was strongly based on a vertical approach, the PHC package was aimed at defining services per level of facility as a way to maximize the integration of services (Department of Health, 2001a: 8).

## Problem statement

The year 2008 marks the 60<sup>th</sup> anniversary of the World Health Organisation (WHO) and the 30<sup>th</sup> anniversary of the Alma Ata Declaration advocating PHC as the main strategy for achieving Health for All by the year 2000. Over 30 years ago, integration of health programmes was first raised at the Alma Ata conference and was considered a way of achieving Health for All. With health system development, the sector-wide approach and decentralization, integration has once again been put at the foreground of current debates. Since it came to power, the aim of the

South African government has been to create a unified, single national health service for South Africa (ANC, 1994: 59). The government committed itself to transform the health sector in order to unify the fragmented health services at all levels into a comprehensive and integrated national health system, where provincial and local authority nurses would be employed by one authority. Despite the dedicated efforts since 1994 to integrate PHC authorities and services under one umbrella and into a seamless public service, ongoing structural and functional fragmentation of PHC in South Africa still remains a far cry from the desired integration that a well-functioning district-based PHC service strives for.

In South Africa, integration of services policy was enacted in 1996 with the aim of increasing health service utilization by increasing accessibility and availability of all health care services at PHC level (Tint, Fonn, Khuzwayo and Robertson, 2000: 15). The current integration debate in South Africa, particularly in KwaZulu-Natal (KZN) includes a slightly different focus from the debate that is related to the fragmented nature of health services, inherited by the democratically elected government in 1994. There has been a pressing need to co-ordinate local authority and provincial services, previously separately responsible for preventative and curative care respectively, and to bring together services offered through authorities in the former homelands, with new provincial and national structures. This type of integration is structural and has unique organizational requirements. The critical element that impacts on the provision of integrated services at the primary level relates to the interaction between the provincial and local spheres of government. This interaction is further complicated by the different capacities within the different municipalities (Department of Health, 2001a:3).

## Significance of the Study

PHC is an approach which has the potential to achieve both the Millennium Development Goals (MDGs) and the wider goal of universal access to health through acceptable, accessible, appropriate and affordable health care (Walley, Lawn, Tinker, Francisco,

Chopra, Rudan, Bhutta and Black, 2008). However, there is a growing consensus that a primary bottleneck to achieving the MDGs in low-income countries is health systems that are too fragile and fragmented to deliver the volume and quality of services to those in need (Travis, Bennet, Haines, Pang, Bhutta, Hyder, Peilemeier, Mills and Evans, 2004). Thus PHC, if implemented, would advance health equity in all countries rich and poor and as a result, promote human and national development (Walley et al., 2008). Although the drive behind IPHC was to improve accessibility of services to the community the problem, however, arises in the implementation of integrated PHC as there is no agreed upon understanding of what this phenomenon means in the South African context. Hence, there is a need for shared views on this phenomenon in order to facilitate an effective implementation of this approach. This study should bring a shared meaning of the phenomenon integrated PHC in South Africa to guide policy formulation and implementation as the country continues in its efforts to achieve a comprehensive and seamless PHC delivery system.

## Aim and objective of the study

The aim of the study was to analyze the concept integrated PHC (IPHC) within a DHS in the province of KZN in South Africa so as to arrive at a shared meaning of the phenomenon. The objective of the study was to analyze the phenomenon IPHC and the meaning attached to it in order to determine the participants' understanding of IPHC.

## Research design

A cross-sectional study, using a qualitative approach was employed in this study. It is crucial that the method chosen is one that is most likely to yield a framework grounded within the South African health systems context. Although a number of views and/or opinions have been advanced regarding PHC and its state of delivery in the country, very little or none has been done to examine the meaning of PHC integration within the South African context and as such develop a common frame of reference for policy development, implementation and evalua-

tion. Hence, the grounded theory approach was selected as it is a method known for its ability to make greatest contribution in areas where little research has been done and when new viewpoints are needed to describe the familiar phenomenon that is not clearly understood (Chenitz and Swanson, 1986: 7). There are two approaches of grounded theory; the Glaserian (after Barney Glaser) and the Straussian (after Anselm Strauss). The root of the difference between Glaser and Strauss lies in the diverse philosophical stances held by the two researchers and their consequential ontological, epistemological and methodological implications (Annells, 1996: 387). They differ in how they view the procedures and processes of grounded theory.

Strauss and Corbin (1990: 23) allow for priority theory, technical and non-technical literature and personal as well as professional experience to enter the field of research. They further state that all kinds of literature can be used before the research study is begun and during the study itself. Strauss and Corbin warn that the previous knowledge should not be taken as a given, testable framework on how to explain a phenomena. Instead it should serve as a source of inspiration. These authors further argue that selective sampling of the second body of literature review should be woven into the emerging theory during the third stage on grounded theory induction, the stage that is termed concept development. This is supported by Smith as cited by Hunter, Har, Egbu and Kelly (2005: 59) in suggesting that general reading of literature may be carried out to obtain a feel for the issues at work in the subject area, and identify any gaps to be filled using grounded theory.

As a result of these divergences, it is incumbent on every researcher using grounded theory to indicate which implementation of the methodology they are using. Strauss and Corbin's approach was seen as more appropriate for this study because a review of literature on PHC within a district health system provided some background knowledge. This was invaluable in facilitating interpretation of participants' understandings and meanings attached to the concept IPHC.

## Sampling of participants

Qualitative researchers collect their data in real world, naturalistic setting (Polit and Beck, 2004: 248). In grounded theory the selection of settings is directed by relevant concepts. An essential feature of grounded theory research is the continuous cycle of collecting and analyzing data. Purposive sampling is generally accepted as a critical feature of grounded theory. A three stage selection plan was applied to select a sample from the accessible population. The first stage of the selection involved the purposive sampling of those health districts that purported to have implemented integrated PHC in KZN. The researcher then purposively selected regions according to their geographical location since the boundaries of the health district coincide with the district and metropolitan municipal boundaries. These districts are central (Health district A), midlands (Health district B), south (Health district C) and north (Health district D). Health districts A and B are situated in urban areas and Health districts C and D are situated in rural areas. There are 61 municipalities in KZN: 1 metropolitan area (Category A); 50 local municipalities (Category B) and 10 district municipalities (Category C) (KZN Department of Health, 2007). Health district A falls under category A and health districts B, C and D fall under category C.

The second stage of the selection involved purposive selection of clinics located within these four districts to collect data on integrated PHC; some of which were under the local authority and some under the provincial services. Only those clinics which had purported to have implemented IPHC were included in the study. The third stage involved selection of study participants. These included policy makers at the district, provincial and national levels that were involved with PHC coordination. In addition, nurses at functional level were included in the study. Selection of participants at the various clinics continued until data saturation had occurred. To be exact, observations were done in 32 clinics. Out of 32 clinics, 53% (N=17) were located in urban areas and 47% (N=15) in rural areas. The sample size for interviews comprised of 38 participants. Of these,

six were policy makers; including one National Deputy Director, one Provincial Deputy Director for PHC, four Programme Managers from the four selected districts. From each sampled clinic per municipality, a professional nurse-in-charge or the deputy in case the person-in-charge was not available, was interviewed. Therefore, at functional level, 28 professional nurses-in-charge and 4 deputy professional nurses-in-charge were interviewed.

## Data collection

The collection of data was done by means of observation and in depth individual interviews. The process entailed non-participant observation of the clinic processes in the provision of IPHC. Essentially, the aim was to observe how the services were offered from the time a patient arrives at the clinic until discharge. Observations included looking, listening and asking questions as they arose out of observations in order to offer insight into what was observed.

Individual interviews were then conducted with one PHC nurse, preferably the person in charge at the clinic level after doing the observation. The two broad questions that were asked to facilitate the discussion were, in your view:

- What is the meaning of integrated PHC?
- What is the nature of events regarding the integration of PHC services?

In addition, questions of clarification based on the data that emerged during observations were included during the interview. Glaser maintains that in grounded theory "there is no such thing as observation without interviews to give them meaning; the reverse is also true" (1998: 109). Purposive sampling of clinic nurses continued until participants had no new information to share. A tape recorder was used to backup the notes compiled during the interview sessions. Hand written notes were utilized to provide backup information throughout the process of data collection. The interviews were transcribed within 24 hours of being conducted, together with the field notes, formed the database for the research.

## Data analysis

The researcher used Strauss and Corbin's process of data analysis. According to Strauss and Corbin (1990:61-117) at the heart of the grounded theory are the three coding procedures: open coding, axial coding and selective coding. Open coding is the process of breaking down, examining, comparing, labeling and categorizing data. The product of labeling and categorizing are concepts. Subsequently, data was compared and similar incidents were grouped together and given the same conceptual label. The process of grouping the concepts at a higher, more abstract level is termed categorizing (Strauss and Corbin (1990:61). Microanalysis approach was used to generate the categories. Strauss and Corbin (1998:57) define microanalysis as "the detailed line-by-line analysis necessary at the beginning of a study to generate initial categories and to suggest relationships among categories". Axial coding involves connecting categories found in open coding. Selective coding involved the integration of the categories to form the theoretical framework. The process outlined by Strauss and Corbin refers to a grounded theory process aimed at theory generation. Hence, a modified approach was used in this study. This entailed identification of themes and patterns in the interview data and correlating these with the observed processes in the clinic in order to generate categories and themes that would describe participants' understanding of the phenomenon IPHC. Essentially, only open and axial coding processes were used.

## Scientific Rigour

There are no agreed upon criteria for evaluating the quality of research using the grounded theory. In fact Rolfe (2006: 304) makes a compelling argument in positing that

*"If there's no unified qualitative research paradigm, then it makes little sense to attempt to establish a set of generic criteria for making quality judgments about qualitative research studies. We need to acknowledge that the commonly perceived quantitative-qualitative dichotomy is in fact a continuum which requires a continuum of quality criteria ..."*

However, in agreement with Porter

(2007: 79) the suggestion by Rolfe that aesthetic or rhetorical criteria could be used to judge the quality of qualitative research negates all that is believed about scientific inquiry.

To enhance internal validity of the study, triangulation was implemented by utilizing multiple sources of data (Polit and Beck, 2004: 432). These sources included policy makers at national, provincial and district levels. For method triangulation, different methods of data collection were used and these included observations and in-depth interviews with participants. The intention was to conduct cross checking, filling of gaps and verification of categories and concepts that emerge from the data. This is supported by Chenitz and Swanson (1986: 88) who state that the use of participant observation and formal interviewing increases validity by decreasing reactivity of the subjects.

These authors further argue that validity is increased since it assures that the truth in the observations is checked with the active questioning of the interview situation. The basic assumption is that the respondents are telling the truth.

## Ethical considerations

Permission to conduct the study was obtained from the KZN Department of Health. Authorities from the different institutions concerned were approached for consent to conduct a study. The rights of participants were safeguarded through written informed consent and confidentiality. Participants were assured that participation in the study would not in any manner affect their lives in the settings either as employees or consumers. Participants were informed that they were free to withdraw at any time from the study.

## Results and discussion

In the context of this study, it emerged that there were three core categories that were used by the participants as discriminatory dimensions of IPHC in South Africa. These core categories were:

- Comprehensive health services
- Supermarket approach and
- One stop shop.

## IPHC as comprehensive health care

Comprehensive health care emerged as the central theme around which the meaning and/or understanding of IPHC revolved. The following excerpts from the interviews with PHC nurses support this theme:

*"I understand IPHC as a basket of services that must be available in the clinic in order to address all the needs of the community as stated in the comprehensive PHC package. In other words, the clinic must provide comprehensive services to the community".*

*"We are providing daily services that are needed by the patients. We work from Monday to Sunday in order to be able to provide comprehensive health care services."*

*"It has to do with the comprehensive services where you offer preventive, curative and rehabilitative services. All the services are interrelated, for example, if you treat a patient infected with Human Immunodeficiency virus (HIV), you do not look at HIV only. You look at the opportunistic infections like tuberculosis (TB) as well as social aspects to ensure that the patient is managed holistically. If a patient has a sexually transmitted infection (STI), you do not look at STI only. You refer them for voluntary counselling and testing (VCT) and you also do a Pap smear. In other words it means rendering of all services that the patient needs comprehensively."*

As noted elsewhere *"there's no adequate single concept for this term (comprehensive health care)"* (Gwele, 1994: 84). The guidelines from the Health Act (no. 63 of 1977) describe comprehensive health services as that which "gives equal attention to promotive, preventive, curative and rehabilitative services" (Cited in Gwele, 1994: 85) The Comprehensive Primary Health Care Services Package for South Africa provides a detail of services that should be offered at various levels of care including the inputs and processes required (Department of Health, 2001a:7). It is not surprising therefore, that for the participants of this study provision of comprehensive health care services emerged as the central theme around which the concept of IPHC revolved.

As the central theme/category and thus the ultimate focus of the service, com-

prehensive health care demanded that clinics find approaches/strategies that would make the attainment of comprehensive health service ideals feasible for their own particular contexts. Comprehensive health care as a strategy for ensuring the availability of a range of services was identified as a common theme among provincial and local authority nurses. This is in keeping with the principles of PHC and the PHC package for South Africa, which state that the clinic should render a comprehensive integrated PHC services (Dennill, King and Swanepoel, 1999; Department of Health, 2001a). Not surprisingly the selection of the appropriate approach for the clinic was guided by a number of factors, including:

- The size of the clinic
- The number of nurses available
- The level of competency of nurses in terms of skills and training
- The availability of equipment
- The availability of space in relation to the waiting area and consulting rooms
- The structural set up of the clinic.

Emerging from this context driven approach to comprehensive health care services, were two approaches through which IPHC would be implemented; including the supermarket and one stop shop approaches.

## IPHC as a supermarket approach

The concept “supermarket” is not a health care service intervention. It originates from the retail sector. According to the findings of this study, IPHC was conceptualized as a supermarket approach where patients that required more than one service were seen by different nurses allocated in different consulting rooms. These patients had to join different queues in order to access different services. This was observed mostly in larger clinics. The following excerpts from the interviews with the participants demonstrate this: *“IPHC is an approach where the nurses offer all the services that the patient wants under one roof. It does not necessarily mean that a patient will access all services in one consulting room but it means that the patient will get all other services in the clinic.*

*All the services that are needed by the patient are available in the clinic. This includes ante natal care service, Family Planning (FP), mental health and other services. It is a supermarket service. It is like going to OK Bazaars. If you go to OK, whether you want needles or you want meat or you want mealie meal or hardware, it is there under one roof.”*

*“It is a supermarket type of an approach. The patient must be able to access all the services that she needs, and not to leave the clinic and go elsewhere. When you go to Shoprite, you get everything. There are items that are kept in the fridge; there are things that are kept in shelves. Everything is well organized. We think of the very same shop when we integrate services in PHC.”*

*“It is a supermarket approach where we do everything for the patient before she leaves the clinic. The patient will not be asked to come to the clinic on different days for different services”.*

Today’s world health care is plagued with increasing cost, long lines for obtaining quality care, inconvenience and inaccessibility, and duplication of efforts. Shah, Bruni and Darling (2002: 106) argue that a similar situation existed in the food and food products industry where one had to go from shop to shop to buy different items. These authors state that consumers did not have knowledge of the quality of each and every product and prices could be unreasonable and bargained. The revolution in the food and food products was the “supermarket model” whereby consumers were guaranteed quality products at a reasonable price and the availability was great.

According to Halper (2006) supermarket is a difficult term to define. To understand such a complex and important institution, Halper argues that “one needs to know the origin, the components that make it what it is and how its business model was molded” (2006: 253). The supermarket got its start in the very early phases of the Great Depression and was molded by World War II. Michael Cullen, a Kroger assistant store manager launched America’s first supermarket on 4 August 1930 in an effort to cut costs while improving customer services. The 1930s saw the rise of the self-service supermarket

as we know it today. Self-service reduced the cost of store operations, and the savings were passed on to the customers in the form of lower prices. Lower prices, in turn boosted sales volume and profits. Large stores made it possible to carry many more product categories without sacrificing the depth of inventory that makes it possible to avoid turning away customers looking for the numerous well-advertised products available (Halper, 2006).

In the health care sector, the supermarket approach was initiated in Tanzania and has been successfully adopted in several East African countries. According to the Report of the Study Group on integration of health care delivery, the emphasis of this approach is client-oriented and provision of all services at the time of visit to the clinic (WHO, 1996). However, the process that is followed in Tanzania for the implementation of this approach is not described. The South African handbook for Clinic/Community Health Centre (CHC) Managers also describes the supermarket approach as the daily provision of all services to the community but does not specify how these services will be offered (Pillay and Asia, 1999). More recently, in the UK the supermarket approach to health service delivery is re-surfacing. Kendall-Raynor (2009: 10) reports that community nurses are beginning to explore ideas from supermarkets in order to improve their own productivity, including “ways of organizing their working environment as part of the productive community services programme”.

## IPHC as a one stop shop

IPHC was also conceptualized as the provision of services to the patient by one nurse. Functional integration as explained before, meets both patient and organizational needs since the patient receives the comprehensive package of primary health services in one location, in one visit. Toomey (2000:14) refers to this approach as a one stop shop. The comprehensive primary health care service package for South Africa states that through a one-stop approach, the facility provides comprehensive integrated PHC service for a minimum of eight hours per day, five days a week (Department of Health 2001b:12). In support of this, Harrison

(1997: 29) argues that one stop shop will ensure that people are treated as a whole not in “bits and pieces” like body parts. Tint, et al. (2000: 15) state that IPHC implies that services will be rendered by the same provider(s) in the same consultation in one visit. The following extracts are a representation of some of the responses from the participants with regard to the understanding of IPHC:

*“We are using a one stop shop, so the nurse does everything for the patient because we have our rooms packed with all the equipment and drugs needed to provide all the services so as to avoid delaying the patient. If I run out of drugs, I personally go out of my room to get the necessary treatment for the patient.”*

*“The nurse will do everything for the patient to avoid any delays. Our rooms are well equipped and have drugs in our rooms. We serve a very poor community who is in a hurry to go back to the fields, so we do not want to delay them. Our staff members have developed bonding with their patients so we try to do everything for the patient so that the patient is comfortable to list all his/her ailments.”*

“I will render all the services that the patient wants except immunization that will be prescribed and the child will be taken to another room for immunization because vaccines are kept in one place for the reasons of the cold chain and economic reasons like saving those vaccines that can never be opened for less than children”.

In the USA, Sage (2007: 503-519) reports on the emergence of retail medical clinics. According to him these retail clinics share a number of distinctive features; they are open till late, some are completely run by nurses and/or physician assistants. Admittedly, the PHC clinics are in no way comparable to this phenomenon, except perhaps for the principle of increased access at affordable cost.

The results of the study that was conducted by Messinger and Narasimhan (1997) revealed that greater prevalence of one-stop shopping was in response to growing consumer demand for time-saving convenience. However, one cannot be sure if one stop shop saves time as it may take longer for one nurse to provide all the services required by the patient.

## Conclusion and recommendations

IPHC is context-driven. The phenomenon, IPHC means different things to different contexts. According to Owen (1998: 67), a contingency approach to an organization takes a different view. There is no one best way to describe IPHC. In a country with such huge inequities in the distribution of health services and related enabling factors such as staff adequacy, infrastructure etc., whether a supermarket or one stop shop view of IPHC underpins practice, is always going to be a function of the context in which the PHC practitioners have to function. Of essence, is that the patient, the practitioner and the service should find meaning in what works for all concerned. IPHC was put in place to improve accessibility of services to the community. However, the important patients’ voice is silent in this study. Therefore, further research is needed to assess the impact of such approach to the community or client satisfaction.

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