HEALTH/HEALTH SERVICES

by Steve Knight

In assessing the effects that access to services have on rural-urban linkages and the urbanisation process, health or primary health care is more important to consider than health services.

There are different levels of health services:

Primary - e.g. a consultation of a patient with a GP
Secondary - e.g. Hospitalisation for a common problem
Tertiary - e.g. Specialist care

There are different types of preventative health -

Primary - Vaccination against disease such as polio
Secondary - Prevent a condition from getting worse
Tertiary - Rehabilitation

PHC includes primary clinical care, primary community care and preventative health.

"Health for All by the Year 2000" (HFA) is the World Health Organisation's overall aim. Primary Health Care (PHC) is seen as the key to achieving HFA.

The original description of PHC put forward by the World Health Organisation at Alma-Ata in 1978 and reaffirmed at Riga in 1988 is a splendid and succinct definition. Primary Health Care (PHC) is defined as essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community by a means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the health system, bringing health as close as possible to where the people live and work.

PHC is not:

- primary medical care - prescribing pills and potions to patients
- only first contact medical or health care
- only health services for all - although this aspect is the easiest to measure and to comment on.

PHC is intended to:

- reach everybody, particularly those in greatest need;
- reach to the home and family level, and not to be limited to health facilities;
- involve a continuing relationship with persons and families;
- involve communities and individuals in their own health.

Essential health care includes:

Promotion of proper nutrition,
Adequate supply of safe water,
Basic sanitation,
Mother and child health care,
Immunisation against the major infectious diseases,
Prevention and control of locally endemic disease,
Education concerning preventing health problems and methods of preventing and controlling them,
Appropriate treatment of common diseases and injuries.

Primary Health Care is in other words too important to be isolated and defined solely within the health sector. It is concerned with a developmental process by which people improve both their lives and lifestyles.

Accessibility is an important PHC principle in attaining Health for All.

How big a problem is movement of people within the health service?

Cross Boundary Flow:

Natal/KwaZulu is divided into 9 Health Planning Subregions (HPSR). During 1987, 59 hospitals were surveyed to see whether the inpatients came from the HPSR in which the hospital is situated or from outside the HPSR. The outflow of patients to adjacent HPSR's from a particular HPSR ranged from 85 727 for the Durban HPSR to 373 393 for South Coast HPSR, representing 3,9 per cent and 36 per cent respectively, of the particular HPSR total catchment population.
Net flow varies from -222253 to +685443. This flow could be explained by saying it is towards the tertiary hospitals situated in the regions. But this does not tell the whole story.

How does this patient flow affect an overburdened tertiary hospital out-patient department?

A survey was conducted in the pediatric department of King Edward hospital to determine firstly the proportions of new patients attending Pediatric out-patients department (POPD) who were referred and who could have been treated in a primary health care facility and secondly, whether unreferred, as compared to referred, patients present more often with problems that are primary care in nature. A large proportion (42,2 per cent) of the 80 000 patients who attend POPD could have been treated in a PHC facility. 78,5 per cent of patients were unreferred. Visits by unreferred patients were more often unjustified (48,6 per cent vs 18,6 per cent in the referred group.)

Why do patients attend King Edward Hospital in preference to their closest health facility?

Many patients cited specific concerns about peripheral hospitals and clinics. They complained that facilities were often inaccessible, as they were located far off available bus routes, requiring a lengthy walk, and had only limited operating hours which conflicted with their working hours. In contrast King Edward Hospital was easily accessible by bus or train and was always open.

Some parents expressed concern over political unrest in the townships and viewed King Edward Hospital as a safer alternative. There are an array of operational problems in the clinics. Supplies are often exhausted, consultations from doctors were preferred to those from nurses. Overall parents believed their children would receive better treatment at King Edward Hospital than in the more peripheral health facility.

How does access to health affect the rural/urban linkages?

Essentials of Health

Primary health care services are not equitably distributed between rural and urban areas in the Natal/KwaZulu region. Access to some of the essentials of health would undoubtedly have an affect on urbanisation.

WATER:

People in rural areas still collect water from unprotected sources, and sparsely scattered pumps, whereas these days most urban areas are to some degree supplied with potable water.

SANITATION:

Access to sanitation probably does not influence the urbanisation process. Although the numbers of toilets in urban areas is significantly higher than in rural areas, the demand for pit latrines is not as high where superficial burying of faeces is still possible.

NUTRITION:

There is some evidence that certain rural areas have less malnutrition than some urban areas. The food available however is difficult to get at compared to the ease of purchasing supplies. Drought and increasing consumerism counter this as a factor in hindering urbanisation.

Transport and communication access have been discussed already. These affect health.

It is access to the other essentials of health - mother and child care, diagnosis, treatment and care of common conditions, prevention of endemic diseases and supply of basic medical supplies and drugs - that are easier to measure.

Availability of Medical Practitioners:(Figures 1 and 2)

Health is traditionally considered the work of the medical practitioner. How accessible are doctors in this region?

Health Care Facilities per population (Figure 3)

The overall clinic per population in Natal/KwaZulu is 1:26 850. There is a marked range in between subregions. The worst region, Newcastle, has a ratio of 1:59 105. The region with the best clinic to population ratio is Empangeni (1:16 163). Ideally a clinic should serve about 10 to 15 000 people in a given geographic region.

These clinics are operated by Professional Nurses (PN's). Only about 20 per cent of these PN's are specifically trained to work in the clinics. A large proportion of the work they are doing is work traditionally done by medical practitioners. They work mostly unsupervised, in remote areas and with poor support from the health service. In the Northern region clinics were receiving one visit per month from a medical practitioner and a single visit a quarter from a matron. Community Health Workers and real involvement of communities in their own health is really just beginning in this region.

Cost accessibility

There is a variability of attendance in clinics and hospitals with the time of the month, significantly more during the week after pay-day as compared to the last week of the month. Much stricter cost control is carried out in the urban than rural areas. People attend for medical care late and one of the commonly given reasons is the cost of medical services.

Distance accessibility

The WHO has recommended PHC facilities should be 3 kms or 45 minutes walk from where people live. People living more than 5 kms from a health facility had significantly poorer vaccination coverage than those living closer to the facility.

Time accessibility

Urban clinics and health facilities are more likely to be

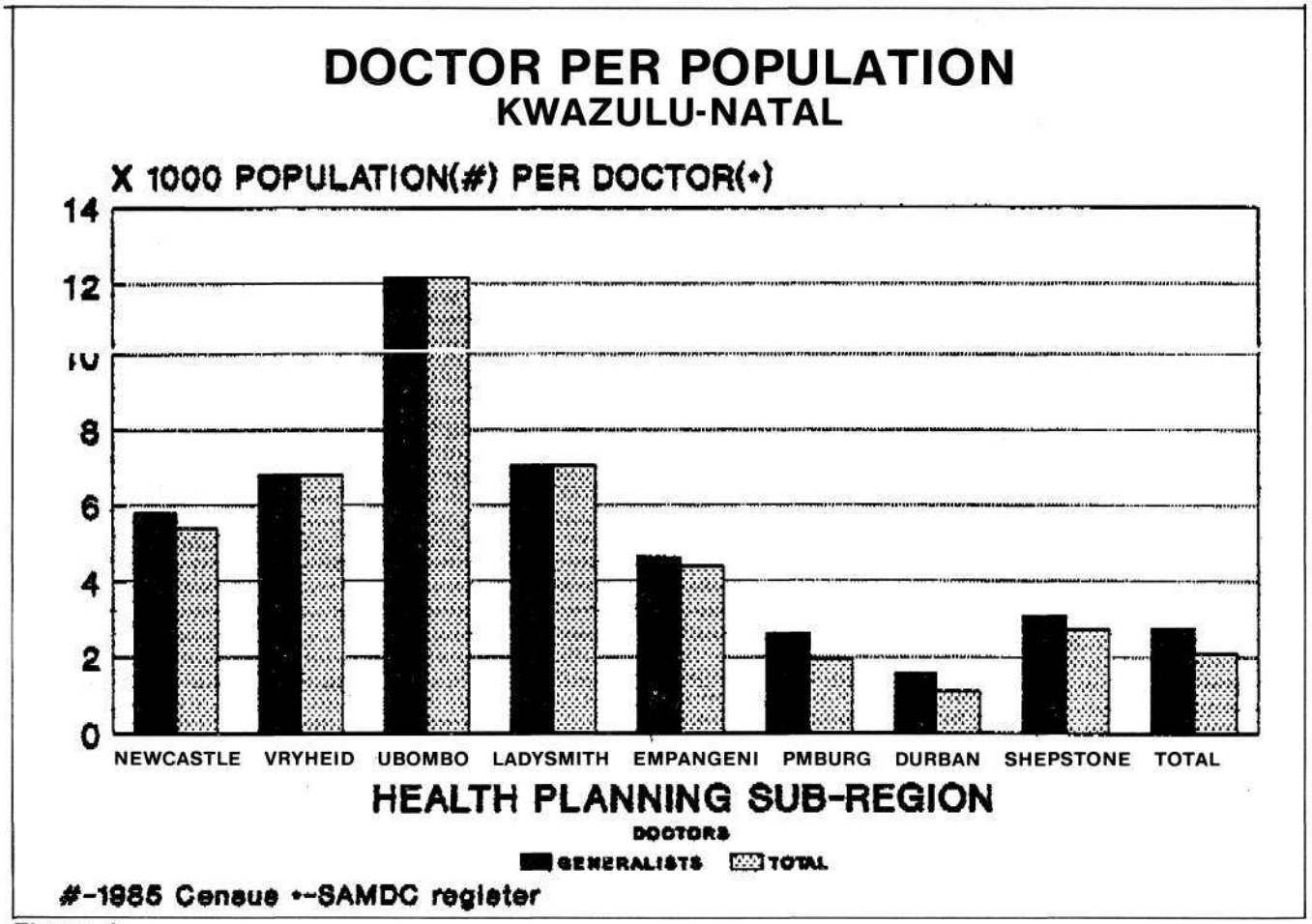

Figure 1

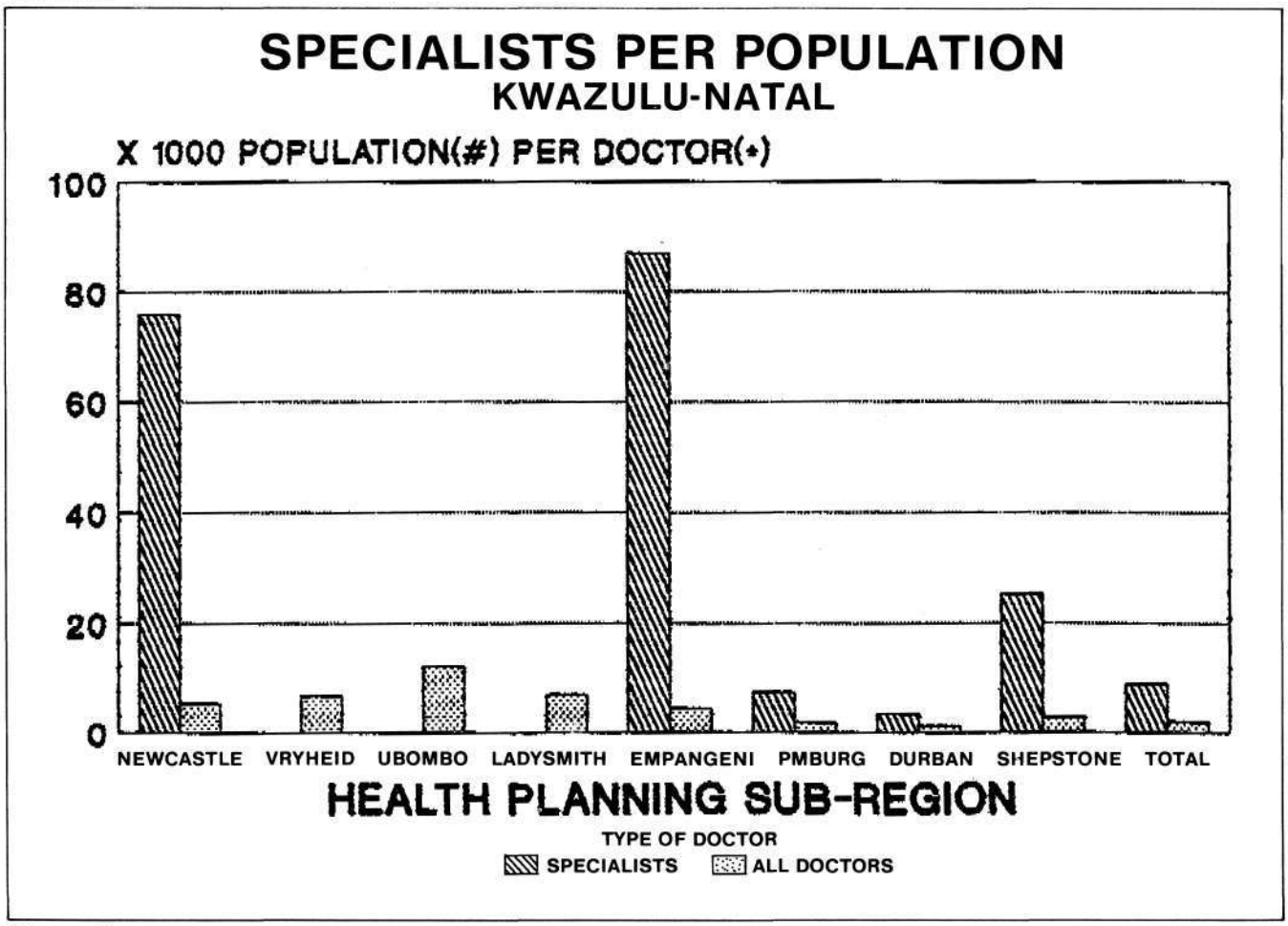

Figure 2

open 24 hours per day, and so enable workers to attend for health care after normal working hours.

Intellectual accessibility

People must understand what is happening and sense that the service wants to see and serve them. This is a major problem with health services in this region.

There are many health related factors that could affect urban/rural linkages. Access to primary health care is an important factor and is probably more important than access to health services only. Not all aspects of health or health care would encourage the urbanisation process. □

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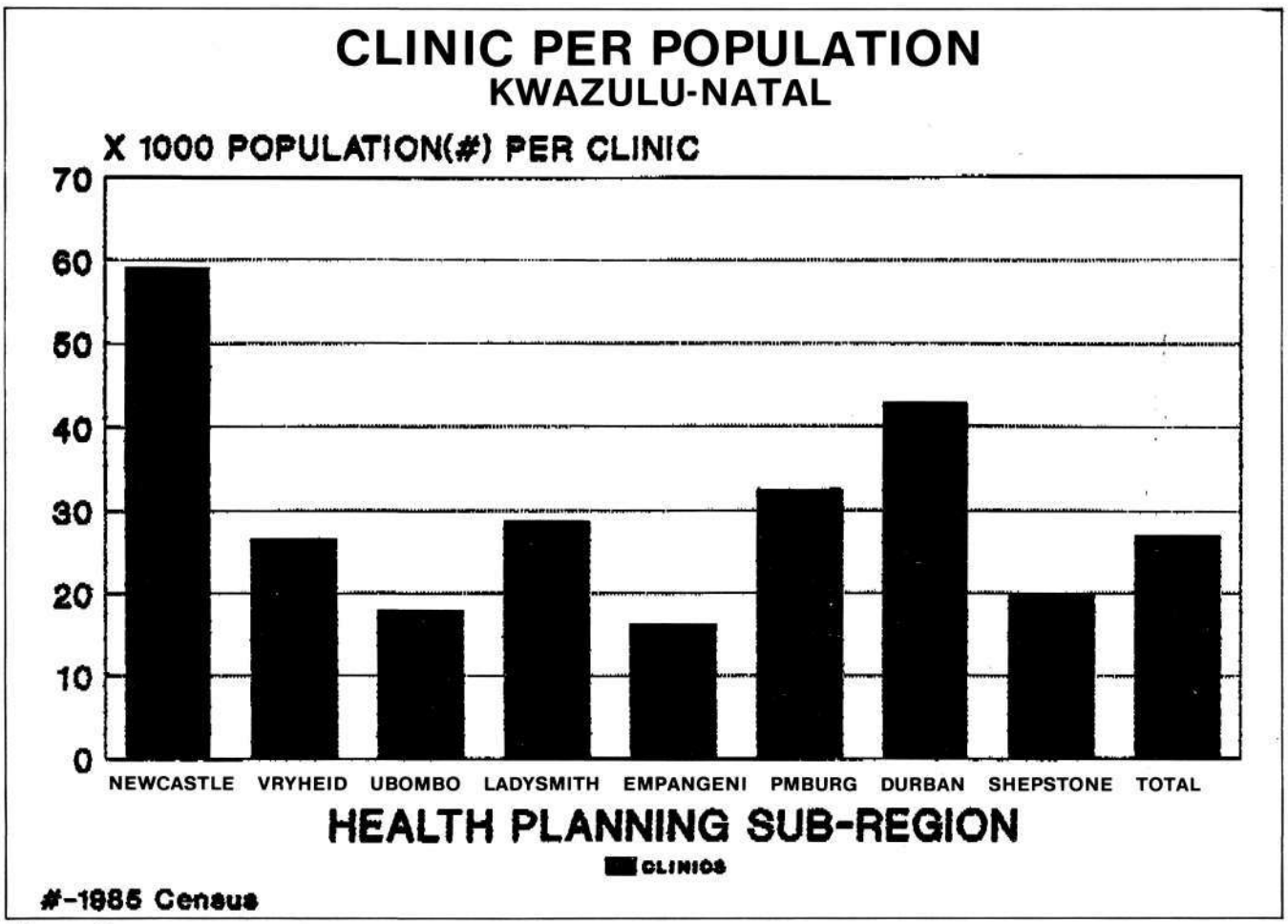

Figure 3