HOME CARE

J. P. Samson M. Cur.(U.P.)

Address prepared by Professor J. P. Samson, at the time head of the Department of Nursing, University of the North, for a conference on Mankind and Medicine in the third Millenium held in 1976 at the University of Stellenbosch.

OPSOMMING

Tuisversorging is wesenlik 'n faset van gemeenskapsgesondheidsorg in sy mees omvattende betekenis. Alles moet dus in die werk gestel en alle moontlikhede ontgin word om dit beskikbaar te stel aan almal wat dit nodig het, en om dit 'n integrerende deel van alle toekomstige stelsels van gemeenskapsgesondheidsorg te maak.

IT is probably safe to state that even in highly developed countries, by far the most un-wellness, ill health, discomfort, and pain are suffered at home, whether before, after, or without having had recourse to available primary, secondary or tertiary health services.

Most people will delay as long as possible in calling in a doctor or going to a clinic for professional assistance or advice, preferring to try out all kinds of home remedies and medicines obtained from the local chemist, and hoping to feel better by tomorrow.

Practically no one ever wants to go to hospital. And when perforce one has to be hospitalised, the first thing the majority of patients ask, as soon as the acute stage of their condition has passed, and sometimes even before then, is: "Doctor, when can I go home?"

We build purely functional or highly sophisticated, single storey or multistorey, rural or urban hospitals, and establish a multitude of decentralised, non-residential health care facilities. Patients are discharged from the former and referred to the latter, or to their private medical practitioners' surgery, for follow-up treatment and/or routine checking.

This referral presupposes a base from which they will travel to the health centres or clinics, and some means of getting there and back.

Not all people so discharged and referred, however, find it possible to undertake such journeys; others are discouraged by the resulting fatigue and discomfort from continuing their attendance. For these people, as for countless others who do not need hospitalisation in the first place but do need primary health care but cannot get to a health centre, home care service can mean the difference between protracted or rapid recovery, between anxiety and peace of mind.

HISTORICAL OVERVIEW

Home care is older than hospital care. It has been a concomitant of family and community life from primitive times to the present. Assistance in childbirth, protection of children, care of elderly and sick members of the family, has been given by the women of the household since time immemorial, and still is. "Simple procedures for the care of the sick were adopted; skills in practising these remedies were improved; knowledge of the efficacy of these treatments spread from one community to another and was passed down from one generation to another". (2, p. 2).

From early Christian times, charitable organisations and dedicated compassionate individuals have given nursing and social care to the sick, both in their own homes and in the hospices and hospitals of their times. From the first century Deaconesses of St. Paul through to the 17th century Sisters of Charity of St. Vincent de Paul, to the 19th century Society of Protestant Sisters of Charity (2,pp 67-72, 132-136, 202) and Matilda Smith's Cape Ladies' Society for the Relief of the Poor (5, p77), to the 20th century Suid-Afrikaanse Vrouefederasie, A.C.V.V. and countless other voluntary organisations, charitable service to the sick and deprived in their own homes has been and still is part of the health care history of mankind.

Up to the beginning of the 19th century, hospital care was intended principally for, or utilised principally by, the homeless — soldiers, sailors, vagabonds — and the destitute and incapacitated poor. This European tradition was transplanted by the settlers to our own country, where health care for the citizenry, the rural population, and their servants, was based mainly on folk medicine and home nursing, while the village wise women ("ou tantes") assisted women in childbirth in all those areas outside the range of practice of the sworn midwives. (5,pp 54-56; 76 seq).

Trained nurses have been involved with home care since the earliest, rudimentary training schemes were started. Almost a century before Florence Nightingale, Franz Anton Mai in Mannheim started a 3-months formal training course for midwives, whose practice in those days was entirely home-based (6,p.108); when the

Fliedners started the Kaiserswerth Institute in 1836, they sent their deaconesses out to do, amongst others, private duty and home nursing (2,p.202 seq). William Rathbone organised a training scheme for hospital, private duty and district nurses at the Royal Infirmary in Liverpool in 1862; these district nurses were to give "nursing care and comfort to poor patients" and "teach families to improve their standard of living" (2,pp.274-5).

In South Africa, White and Coloured midwives for domiciliary practice were trained in the Cape Colony since 1810 (5,p.97). Sister Henrietta Stockdale, who started the first formal training of general nurses at Kimberley in 1877, organised a private duty home nursing service, by trained nurses from 1888. Out of this service, a so-called Nurses Co-operative Agency developed in 1895 in Bloemfontein; a similar organisation, the well-known Victoria Nurses' Institute in Cape Town, for more than half a century since its foundation in 1897 provided private duty nurses for home care over a wide area (5, pp. 78, 140).

Home nursing services for lower income groups were introduced in the early years of the 20th century by the Cape Hospital Board for the Cape Peninsula and by various private welfare organisations in different parts of the country. Rural district nursing by White, Black and Coloured nurses, with the emphasis on midwifery but including general nursing as more doubly qualified nurses became available, dates from the middle thirties. Mission hospitals developed a form of district nursing service to the Black population in the remote rural areas (5, p.352-3).

Public Health nursing services cover an additional aspect of home care. Health visiting in South Africa also mainly followed the pattern originating in Great Britain in 1862, when "respectable working women" were first employed by local authorities or voluntary organisations to advise the poorer classes on the rudiments of hygiene and sanitation, and, since 1907, to give domiciliary follow-up care to newborn babies and their mothers, with particular emphasis on infant-feeding. In South Africa, only trained nurses have been appointed since the first Health Visitors or "Lady Sanitary Inspectors" were employed in the Cape Colony in 1901 (5,pp. 354-5).

PRESENT-DAY SERVICES

So much for a brief survey of the highlights in the historical development of home nursing services. What is the position today as regards home care, which embraces more than home nursing, although, in South Africa at any rate, home nursing probably still forms the bulk of home care services?

The following broad home care service areas may at present be identified:

1. Medical and Nursing Services

Domiciliary medical practice, which used to be an integral part of urban and peri-urban health care in developed and developing countries of the Western world, is today becoming more the exception than the rule, as the "pronounced shift in the service pattern away from visits by the doctor to the patient's home to one of the patient coming to the doctor" (4, p.8) gains momentum. Millions of people in developing and underdeveloped areas of the globe have in any case never had this service.

Today, when a patient is too ill or for another reason unable to go to the doctor at his consultingroom or at a health centre or out-patient department, he will, even if not seriously ill, very frequently be hospitalised for diagnosis, observation and/or investigations which require modern diagnostic techniques and aids.

In many countries, in the attempt to keep as many people as possible out of hospital in the first place and at the same time to solve this problem, domiciliary primary assessment of such patients' condition, followed where possible by "remote control" home treatment on the medical practitioner's prescription, is being done by a "doctor-substitute". This may be a semi-trained person, like Russia's Feldscher or China's "barefoot doctor". Many health authorities and professionals however, including those in South Africa, regard this intermediary service to be the proper function of the registered professional nurse, who by virtue of her training and her role as the "extended arm" of the doctor, is increasingly being prepared and employed, both in private medical practice and by public health care authorities, to perform these functions.

The development of this aspect of the modern registered nurse's functions may well lead to the emergence of a new category of nurse in the non-institutional health care field. It has, in any event, implications for the training and practice of the present-day three traditional categories of nurses giving home care services. In our country, these three categories are:

(a) *Private duty nurses,* engaged for full-time or part-time day or night care, by one "private" patient (in rare cases, for more than one member of a family); in cities and the larger towns, nursing co-operatives may act as agents for the employment of these nurses. Fees are high, and only the well-to-do can afford this type of service. Enrolled nurses or enrolled assistant nurses may give semi-skilled general or maternity nursing care to patients who do not necessarily need the professional services of a registered nurse. Self-employed private duty registered midwives are, at any rate in South Africa, becoming a rarity as health authorities stress the adv isability of deliveries in a midwifery department, day or night hospital, or health centre.

(b) *District nurses and midwives,* employed by a central or local health authority, or by a private welfare organisation. They cover a circumscribed urban, peri-urban or rural area (their "district"), attending to the daily nursing needs of a varying number of middle and lower income patients. Visits are brief but not necessarily hurried and cover general, maternity and psychiatric home nursing care. Night visits are generally not included. Salaries are paid by the employer, and patients may contribute according to their income.

(c) *Community or Public Health Nurses,* employed by a local authority or by the Central Government or a Homeland Health Department. Their function in

the home care area is primarily the extension of preventive and promotive health care and follow-up services into the homes of the community. Besides i.a. maternal and child health, tuberculosis and venereal disease follow-up, health education and family planning guidance given in the family setting are important aspects of this home care service.
In many instances, especially in rural communities, public health nurses will give home nursing care when this is obviously needed in a particular home. In the Homeland health services, the public health nurse and the district nurse are frequently one and the same person. This fusing of functions would seem to be a logical development in the effective use of nursing manpower as the functions of the community health nurse and the district nurse in the home care area are becoming more and more complementary.

2. **Social Service**

(a) The social pathological conditions which may have contributed to the patient's physical or mental breakdown in the first place, or which hamper or prevent his rehabilitation, are primarily the concern of *social workers,* who may be employed by a health authority, a social welfare authority, or a voluntary organisation.

(b) Many housebound people, particularly the aged living alone, whether or not they require home nursing care, may need temporary or permanent assistance with domestic activities which they are unable to carry out themselves. In Great Britain and in the U.S.A. for instance, such a service is supplied by part-time *home helps* or *homemakers* who may cook, clean, shop, do laundry and mending, wash and dress children and get them off to school, but who do not do sick nursing, baby- or adult-sitting. "A good home help, in a poorly run household can, by lightening labours and improving nutrition, benefit the health of the housewife, old people and whole families . . . Home helping is closely related to other problems in social medicine and usually accompanied by the need for advice and guidance in other social matters". (1,pp.113-4). In Great Britain, home helps are carefully selected, trained and supervised, "immediate supervision (being) usually exercised by the home nurse for sickness, the midwife for childbirth, the health visitor for old age and infirmity". (Ibid.).

To the best of my knowledge, such an organised home help service *per se* does not yet exist in any part of our country. Some assistance may on occasion be obtained through organisations like the South African Red Cross Society or Noodhulpliga, which besides training in First Aid, run courses in home nursing which include some of the activities mentioned above. Apart from this, intelligent well-trained domestic servants have been an invaluable help to many an invalid and old person for centuries; but even this help is beyond the means of some.

(c) Relief from the necessity of preparing meals is in some of our cities provided by the so-called "meals on wheels" service provided by social or health authorities or by voluntary charitable organisations. This ensures at least one cooked, balanced meal per day to especially the handicapped and aged person living alone, and prevents the malnutrition caused by a diet of tea and bread.

RECIPIENTS OF HOME CARE

Assessment of potential recipients of home care must, for obvious reasons, be based on well-defined criteria. These would differ for people in different areas and different social settings, for particular health service authorities, and for different cultural groups. The home situation as much should also be carefully investigated, becasue not all homes can provide a suitable environment for a particular form of home care.

Broadly speaking, the following categories of persons could be considered as potential recipients of home care:

1. Any person who, for a valid reason, is unable to attend a health centre, polyclinic or out-patient department and whose home situation ensures rest and proper attention; this category would include, i.a., the aged, crippled and infirm, capable of living alone or in a family setting, but who are without adequate and/or suitable transport; newely-delivered maternity cases from health centres or day hospitals; babies and young children with housebound mothers; the borderline, mild or moderate mentally retarded, especially children "who may be expected to reach a much higher level of development because of more personal attention in their own family setting" (3,p.192); those requiring psychiatric after-care in the family setting; and possibly also in the case of certain communicable diseases, home deliveries and the dying.
2. Any person who lives alone, is not seriously ill, but who will be hospitalised either because his particular condition makes it temporarily impossible for him to attend to his own basic needs, or because the doctor wants to keep him under observ ation but his physical disability, transport problems, distance, etc. preclude daily presentation at a clinic; this category could include e.g. the sick husband of a working wife, who needs a little more than the help of kind neighbours or relations.

ORGANISING A HOME CARE SERVICE

Numerous problems beset the organisation and administration of health care services. Partly for economical reasons, "keeping the patient out of hospital" has become an almost universal health service slogan. Decentralised health centres are burgeoning in urban and rural reas, as the concept of comprehensive

health services is being implemented.

I need hardly draw the attention of this audience to the factors which may prevent or delay the implementation of our present-day ideals of a total, integrated, fully comprehensive health service. Economics, official policies and legislation, and manpower problems are probably the three most important.

However, this need not deter us from drawing up a basic scheme for the eventual full incorporation of home care services into the health care systems of the third millenium. The nucleus of such a scheme already exists in various forms, albeit not universally. That the programmers and implementers thereof should take into account, i.a., health and cultural needs and wants of particular societies or communities — "needs as defined by health service personnel, and wants as defined by users of the health services" (7, p.329) — should be self-evident.

In South Africa, full integration of health services is to a large extent still hampered by the tripartite system of central, provincial and local government control; this problem should to a large extent, if possibly not completely be overcome in the foreseeable future.*

In our Homelands, a comprehensive health service under one authority has been developing since 1970. This service is hospital-based and clinic-centred. This is in accordance with present-day thinking on the role of the hospital, seen traditionally if not always correctly as a "curative only" health care facility, in the changing health care services. The hospital is extending its traditional role and it has been suggested that the ultimate responsibility for all community health services, that is "primary care, extended care, rehabilitation, home care and community surveillance and protection services in addition to emergency and in-patient service" might be formally assigned to the hospital system (4, pp.8-9). Whether this is pushing the swing of the pendulum too far, I leave to you to decide.

For the present, it may be possible to develop the principle of integrated home care by linking the service to the decentralised clinics or health centres. This could be done in both urban and non-urban areas where such clinics or health centres are hospital-based. In remote rural areas, assessment of the total situation and not only of individual recipients as to the practicability of a particular programme, is especially important. Mobile sub-clinics conveying teams might prove to be the most effective way of providing a service here.

As I see it, a key figure in organising and administering an integrated home care service is the registered nurse. Her designation does not matter, neither does it matter whether she performs other nursing functions besides home nursing. In fact, it is probably necessary that the registered nurse as team leader of enrolled nursing as well as other auxiliary categories of staff should be a generalist, not only *qua* functions but also as regards her registration in at least two, preferably all three, of the present basic nursing disciplines in this country, i.e. general, obstetric and psychiatric nursing. This could have the added advantage of attracting well qualified staff to such posts if they knew that there was scope for their ingenuity, versatility and expertise. Already, extending the role of the registered nurse by in-service training in primary assessment and first-stage treatment of patients is being done in our Homelands as a practical solution to the shortage of medical practitioners. It is not only in our large city and academic teaching hospitals that the nurse as the extended arm of the doctor is breaking new ground.

* This paper was written in 1976 prior to the passing of the Health Act No. 63 of 1977.

CONCLUSION

"Many believe that the home is the place in which to be ill and wish to see hospital care more specifically retained for those with conditions requiring treatment beyond the capacity of the general practitioner and the home to provide" (1,p.127). Three reasons for this view are advanced: (Ibid.)

- *Social: the study and treatment of the whole person the family setting is one of the objectives of social medicine.*
- *Economic: keeping patients out of hospital relieves the health budget considerably.*
- *Psychological: being cared for at home is preferable for young and old — admission to hospital is disturbing to children; elderly people can retain their family and community attachments.*

From the U.S.A. comes a similar argument: "In view of the rising costs of hospital care, it would seem desirable to handle as much of medical care as possible on a non-hospital basis, and home care, **when feasible,** offers an attractive alternative to hospitalisation at approximately one-tenth of the cost . . . With a satisfactory home environment, many comforts are available that no institution can provide". (3, p.144)

Home care is essentially a facet of community health care in its most comprehensive connotation. Every effort should therefore be made, and every avenue explored, to make it available to all those who need it and to make it an integral part of all future public health care systems.

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