PRIMARY HEALTH CARE THE ROLE OF THE NURSE

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OPSOMMING

In die Suid-Afrikaanse situasie is die verpleegkundige 'n kernfiguur in die lewering van primêre gesondheidsorgdienste.

In die voorsiening van 'n veilige omgewing het sy 'n sekondêre rol in behoefteïdentifisering en voorligting en dieselfde geld vir die aspek van toereikende voeding. Haar rol in basiese voorkomende gesondheidsorg en die sorg van bejaardes, gestremdes en chroniese siekes word reeds algemeen aanvaar.

Dit is op die gebied van sifting, behandeling en verwysing waar daar verwarring oor die verpleegkundige se rol en die meeste weerstand teen verandering is. Verpleegkundiges kan hier benut word en in baie areas lewer sy in hierdie opsig reeds met welslae 'n diens. Sy is nie 'n bedreiging vir die mediese praktisyn nie, daarenteen kan sy hom help en aanvul. Die land se gekwalifiseerde verpleegmannekrag kan ook beter benut word indien die verpleegkundige in privaatpraktyk in hierdie rol gebruik word.

WHAT IS PRIMARY HEALTH CARE?

Primary Health Care, as the words imply, is the initial, or **first** level of health care given to individuals needing or seeking that care. The whole population **needs** primary health care, for it is basic to attaining, retaining or regaining health, or making the best use of what health is left.

In a Joint Report by The World Health Organisation and the United Nations' Children's Fund (1978, p.2.) to the Alma-Ata conference in September, 1978, the following definition was given: *Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the 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 thus not only curative, but preventive, promotive, rehabilitative and maintenance care.

Primary health care is also generally felt to be that form of health care given at the first point of contact of the client or patient with a member of the health care team. That health care team member, in the reality of the South African health care system, is very often a nurse.

In this article other workers are mentioned, many of whom are often forgotten as being health care workers. They are, however, absolutely essential to the provision of basic health services to all members of the community. They are an integral part of the health care system — health care in our present-day social system would be impossible without these workers.

Primary health care, if it is community oriented and is to have community acceptance, as stated by the Alma-Ata conference, must include:

- The provision of a **safe environment.** Safe, that is, in terms of basic hygiene and housing, which will include safe water, food and safe disposal of excreta and other waste matter. This aims at preventing any *first* contact with other health care workers because of ill-health. It therefore provides primary care, or basic care of first importance to health.

- **Adequate nutrition** for all.

- **Basic preventive health care** such as immunisation, ante- and post-natal care, obstetric care, family planning and health education. Encouragement of individuals to accept responsibility for their own health and health practices.

- **Care for the aged, handicapped and chronic sick**

- **Screening of persons** coming for specific health care because of a breakdown in health, and **referral** of those who need secondary level health care to more sophisticated services. This is followed by their **reception back** after treatment, and their **ongoing monitoring** and care at the first basic or primary level once more.

- **Provision of services** needed to ensure that basic health care can reach **all** groups of the population, and not only people in the lower or upper income groups. This includes **all** members of **all** people falling in groups such as: mother and child, toddler and preschool child, school child, adolescents, the groups receiving tertiary education or post-school training, the workers, the retired, the incapacitated and the aged.

Having identified the contents of primary health care, it is now proposed to take a look at those groups of health care workers who will be involved if good primary health care is to be provided for **all** members of the population. In taking an overall look at the workers in each identified area of care, the role of the nurse will be highlighted.

A SAFE ENVIRONMENT

Many persons are involved here, including those who will be foreign to many readers as fitting into a category of primary health care worker, but without whom our health services would be

overburdened, if not brought to a complete standstill. Here are included those who ensure a safe water supply for the community, food that is safe to eat, hygienic standards in public eating places, safe milk, those who ensure adequate sewerage and waste disposal, those responsible for housing, for slum prevention, and for the eradication of infection carrying insects and rodents — all are primary health care workers.

The role of the nurse in this area is secondary, and may be difficult for some to perceive. However, communtiy nurses can identify and point out problem areas such as a breakdown in services, the complete absence of the necessary services in some areas which she visits, or in observing and reporting conditions in the community which are not conducive to healthy living. Here role in this area may also include teaching people how to observe hygienic practices is child and home care which will ensure a safe environment for the family, and thus, for the community.

ADEQUATE NUTRITION

Many agencies are concerned with this, as was only too evident in the recent drought, during which the lack of water and famine were causing so much breakdown in health. Specific workers who are concerned with nutrition, and thus with health, include those in agriculture, dieticians, paediatric specialists and other medical practitioners, as well as nutritionists generally.

The nurse, who so often has **continous direct** contact with consumers of health care, more so than any other health professional, can give informed advice on basic nutritional needs to clients or patients. This is seen very clearly in the area of child health.

The nurse also often has to act as the interpreter of instructions given by others. The patient, the mother of a child, the family member dealing with someone ill at home or recently discharged from hospital, will often ask the nurse for clarification of advice that has been given to them. The need for such explanation often arises from the person concerned not wanting to appear *stupid* to those originally giving the advice, or being too emotionally disturbed at the time to listen properly. Because the nurse has the opportunity for a more *comfortable* relationship with the client or patient than is often possible in the shorter doctor-patient contact, the person is more ready to ask the nurse if there is confusion in her mind about what was meant.

BASIC PREVENTIVE HEALTH CARE

Here the role of the nurse is more readily and generally understood.

Immunisation services are, on the whole, dependent on the nurse for their successful operation.

The **nurse-midwife,** particularly in the rural areas, gives ante-natal and post-natal care and delivers a large number of babies. She knows when she needs the medical man, especially when problems occur which are beyond her scope of practice and expertise.

The **family planning** services also rely, to a very large extent, on nurses to reach the people.

Health education, particularly at a personal, one-to-one level, and not just in the form of a *dose of health educations supplied by posters on clinic walls* as it has been described, can be given very effectively by the nurse. She does this by means of simple, appropriate advice, given at the right time, in the right place, in the applicable situation, using any *teachable moment* which may present itself. She also gives health education, unconsciously and by example, in her work and in community activities.

The nurse can **encourage** the individual to **accept responsibility** for his own health practices, often by subtle means, by reassurance and by tactfully pointing out alternatives. Again, the ready availability of a nurse in hospitals, clinics, in health care centres and in the community makes this possible.

CARE OF THE AGED, HANDICAPPED, AND CHRONIC SICK

This often falls fairly and squarely on the shoulders of the nurse. Physiotherapists and other also have an important part to play, as do medical practitioners who are on tap in case of need. The monitoring of the chronic sick in old-age homes or at home is being carried out more and more by nurses. This is basic, or primary care which is given in these circumstances.

SCREENING, TREATMENT AND REFERRAL

The modern professional nurse, who has completed at least four years of educational preparation, **can** and **is** being used to provide this service in many areas.

Dr. J. Wessels, co-ordinator of primary health care services in the Eastern Cape and Border Area, says in his report dated January 1983, that the chronic shortage of medical practitioners in the densely populated area with which he has been associated, made the provision of health care by selected registered nurses essential if any sort of health care was to be given to the people in that area.

It is in this field of primary health care that the greatest confusion concerning the role of the nurse exists and where the most severe form of the *Resistance to Change* factor is being experienced.

At the outset, let is be clearly stated that the nurse involved in screening, treatment and referral poses no threat to anyone. Her function is to assist and complement, and not to replace the medical practitioner in clinics, out-patient departments and other health services. A medical practitioner can only practise within the parameters of his education, training and expertise — with the professional nurse the situation is exactly the same.

Section 38 (a) of the Nursing Amendment Act of September, 1981 makes provision, in controlled situations, for the nurse to:

— physically examine any person;

— diagnose any physical defect, illness or deficiency in any person;

— keep prescribed medicines and to supply; administer or prescribe them under the prescribed conditions;

— promote family planning,

provided that the services of a medical practitioner or a pharmacist, as the cirsumstances may require, are not available.

The way for the nurse to perform in a wider sphere has thus been legally opened and the South African Nursing Council is at present drafting regulations under this Section of the Act, which will serve as a guide for nursing practitioners and others.

We are all aware that there is a complete maldistribution of medical practitioners in the Republic of South Africa. Beaton and Bourne give the following figures: in 1975 the doctor to patient ratio was 1 to 875 in urban areas and 1 to 12 773 in rural areas. Quite a contrast, you will agree. Further unpublished information from the same source states that 24% of the doctors in rural areas were not South African and that between 1975 and 1981 half of this 24% had disappeared from the Registers of The South African Medical Council. This means that continuity of care and a chance to learn the language of the indigenous population would be very difficult.

In Clinics

Some years back the author had, in the course of her work with the Department of Health, visited many outlying clinics with a large attendance of patients where the nurse was the only health care worker available. Her medical cover often came from a very long distance. Physical visits by doctors to those areas may only occur on a weekly, fortnightly, monthly or even longer spaced basis.

The question must be asked: *Should patients in those areas be left without treatment for such long periods of time?* Surely registered nurses, with perhaps special in-service education to enable them to keep up-to-date and to meet special needs, would be preferable? Some primary treatment at least could be given.

The reality of the situation must never be forgotten. Those who have never been confronted with this type of situation may find it difficult to understand. Nurses in those situations carry the health services, without them there would be none.

In his 1983 report Dr Wessels said that, in the year 1982, the trained primary care sisters were involved in the management of nearly one million patient attendances in his area which, it must be pointed out, also included urban areas. In a personal discussion with the author he was quite emphatic that at least half a million of those treated would have received no care at all if it were not for the primary health care sisters. He stressed that in order to make such a practice possible required recent diplomates from a good educational system who had not yet become set in their ways, or had time to become indoctrinated into the old system. They are specially selected for their knowledge, communication skills and adaptability and can, if given an in-service, updating and orientation period of about one month, function very effectively in such a service.

Another point that Dr Wessels emphasised was that the attitude of the doctors is of vital importance to the success of the use of registered nurses as primary health care workers in the screening and treating of patients. He said: *"I have reason to believe that the resistance by doctors as to the value of the extended role of the nurse is based on a lack of knowledge as to the standard and quality of modern basic nursing education and, furthermore a lack of knowledge of the tremendously high standard of post-graduate nursing training such as the diplomas in Intensive Care, Orthopaedics, and Theatre.* He continued *I make this statement as I have had the opportunity to participate in the teaching of basic nursing and first-aid; tutoring sisters for their diploma courses for paediatrics, theatre, intensive care; and thirdly, and perhaps most important, working intimately with them in the clinical situation of primary care over a prolonged period.*

He also emphasised *It must in the first instance be stressed that the very first objective is to ensure that there is no misunderstanding: our aim is* **not** *to create a* **doctor** *but to create a* **super sister** *who can practise her extended role to the extent necessary as demanded by cirsumstances.*

In the Transvaal, Baragwanath with its eight primary health care clinics, or Polyclinics, handles between 60 000 and 70 000 patients a month and refer less than 4% of these to Baragwanath Hospital.

The primary health care sisters manage 70% of the patients alone, 30% are referred, half to the clinic's primary health care doctors and the rest to dentists, tuberculosis clinics, ante-natal clinics, psychiatric clinics and others. In 1981, these clinics handled a total of 1 790 000 patients who were seen by nurses only. Many more such clinics are envisaged in the future.

It is obvious that maximum use is being made of the potential of nurses in such circumstances. It is the stated policy of the authorities concerned with the provision of health care to all that the services will rely heavily on nurses in the future. There is no other alternative.

As we have seen primary health care also means a basic, or first level type of health care, which, besides that provided in out-patient departments and clinics, is obtained in private practice. Is the maximum use being made of the registered nurse in this area?

In Private Practice

A medical practitioner is quite ready to accept the observations made by the nurse in the hospital situation, but sometimes seems reluctant to make similar use of nurses in consulting rooms. Here they are frequently used for clerical work such as booking appointments, recording visits, obtainig colleagues on the telephone and making tea! Could they not be better employed in taking basic health histories, doing preliminary examinations and carrying out certain tests?

It is not suggested that general practitioners spend less time with their patients — heaven forbid. However, armed with an essenstial health history and some preliminary observations and test results, more time could be spent in talking to the patient, confirming some problem area, deciding unhurriedly on an appropriate form of treatment based on a considered assessment of what he has before him, what he himself has observed and determined, and what his expertise tells him. It is the premise that, by appropriate use of the skills of the registered nurse, primary care in these circumstances could become more meaningful to patient and practitioner alike.

The registered nurse attached to a private practice could also be used to monitor patients at home and for follow-up visits to assess the effectiveness of treatment, just as she does in a hospital or clinic. All this will be within the normal parameters of her professional practice. This type of practice could also lessen the burden of cost to the patient and add to patients' satisfaction with the care that they get.

One argument that might be raised is that there is a **shortage** of nurses. This shortage is probably largely artificial, compounded by the use of nurses for many unnecessary domestic chores which are not directly related to patient care. In December 1981, there were 57 324 **registered** nurses on the registers of the South African Nursing Council. With a population of 25 456 700 this is a ratio of 1 : 444, which is not at all bad especially when regard is had to the fact that only 10% of illness that is treated, is treated is hospitals. Futhermore, there were 18 321 **enrolled** nurses, with a two-year basic training, on the rolls.

Although we know of areas where posts are not all filled, there are others where no posts are vacant, and yet there are not enough registered nurses to meet all the requirements of the service. This is because, as demand for services increased and the work-week shortened, new posts to meet the changed circumstances were not always created. Some of the reasons were of course economic. In our health care system the salaries of nurses have largely to be met out of the health budget of the State or Province or Local Authorities, which limits the possible number of staff increases. Salaries are not the only point at issue in the filling or otherwise of nursing posts, as has been clearly shown by the recent interim report on nursing of the Human Sciences Research Council.

One of the most worrying things is the number of registered nurses who are working, but not in nursing. This is not because they do not want to nurse but because as young wives and mothers, the so-called *unsocial hours* of hospital work make it difficult for them. Set hours in private practice and the use of part-time nurses might bring many back into the profession for which they were trained but which they are not practising.

PROVISION OF SERVICES NEEDED

The provision of services for basic health care to reach all groups of the population is the final element of primary health care. Many people in the community *buy* health services, either in their private capacity, or through their medical aid schemes. For the most part these people have services available if they become ill and also have access to preventive services.

However, there are many, many members of the population in the Republic of South Africa, who do not have access to medical schemes and cannot afford to *buy* services. They would not think of preventive services in any case, except perhaps for compulsory immunsisation for children, and not always even this. It is obvious that if primary care services are to be provided in all the areas such as child health care, occupational health care, health care for students and trainees, the handicapped and the senior citizens, then the services of the nurse must be used extensively.

Most of our school health services operate almost exclusively on nursing personnel. Nurses are also being used in psychiatric services, in oncology services, in genetic services and in primary midwifery services. All of them provide basic, first-line or **primary health care.**

CONCLUSION

The registered nurse follows a controlled educational programme which is constantly undergoing review and revision to meet the changing needs of the times. Nurses from by far the largest group of professional workers in the health field. They are expected to exercise educated judgment in their work. The attitude of those who do make full use of the services of nurses is not in question, but the attitude of those who employ nurses but do not use them optimally, does require examination.

The best possible care of our patients and clients is the aim of all members of the health care team. Improving the quality of that care by the utilisation of the registered nurse, teaching her skills which she can use but which she may not yet have acquired, and accepting her as a person able to make a valuable contribution in the team approach to patient care, can only be of benefit to all.

From what has been said, it would appear that **primary health care** is given by members of the community and by health care professionals, including medical practitioners, pharmacists, dieticians and members of the supplementary health professions, as well as by social workers. The nurse, however, because of the numbers available, the intimancy of her continuous contact with members of the community, well and ill, and her latent expertise which, it has been proved, can be evolved to meet specific needs in a given situation, in many different areas, can be the core figure in the rendering of primary health care.

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