Capacity of the SA public health sector to deliver rehabilitation services: an institutional analysis

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International and national discourses on disability conclude that rehabilitation is a fundamental concept in disability policies and is seen as the process without which many people with health problems leading to impairment and/or disability would not be able to participate fully in society (1). While successful health outcomes for doctors and nurses are measured in how many lives are saved and how many people remain healthy, successful rehabilitation outcomes are judged by the level of integration into mainstream society of people with residual impairments. Social integration is impossible to achieve without effective rehabilitation service delivery. Despite a progressive and enabling legislative framework in South Africa (SA), services for people with disabilities (PwD) somehow are not meeting the needs of both adults and children with disabilities in SA, as demonstrated through continued poor socio-economic status. Emerging evidence that the public health sector is struggling to provide effective, efficient and equitable rehabilitation services, requires due attention to be paid to understanding what these capacity constraints are from a provider perspective.

Witnessing the gap between policy and practice

Through the ratification of international conventions and development of national policy frameworks, a shift has occurred from a narrow understanding of disability as a personal tragedy based on an individual medical response to 'fix the person affected', to an understanding of disability as a result of more complex systems of social restrictions. This resulted in the introduction into SA public health policy of concepts like 'inter-sectoral collaboration'; 'active participation'; 'maximum coverage'; 'empowerment' and 'social inclusion' to guide rehabilitation policy, which were foreign to service provision and to the professional world initially. These concepts are reflected in the social model of disability and demonstrated in the ongoing debates and power struggles to overcome professional dominance in rehabilitation service delivery. Disability and rehabilitation became complex multi-sectoral concepts at a strategic level, but continue to be managed and provided according to profession-specific norms and standards through separate, clinical structures at an operational level (2). What is being witnessed is a conflict between strategic policies and operational structures, resulting in a widening gap between policy and practice.

Rehabilitation service delivery – an institutional analysis

Capacity to deliver services involves the ability to perform appropriate tasks effectively, efficiently and sustainably, which are characteristic for overall public sector performance (3). Since the delivery of public rehabilitation services involves many different role-players as agents at various levels, understanding the institutional context provides insight into how this broader environment impacts on the delivery of effective rehabilitation services.
The institutional context includes such factors as the 'rules and procedures' set for government and public officials to do their work. Rules and procedures are needed for getting things done and getting them done right for day-to-day functioning in service delivery. Rules

have been reported to be poorly defined in the provision of rehabilitation services, as evident through role confusion, lack of coordination and differing approaches amongst the different professionals contributing to a rehabilitation service. Provision differs from manager to manager and organization/facility to facility, thus requiring attention at least regarding the setting up of public sector rules and regulations.
There are four key agencies that play a role in setting up rules guiding the delivery of rehabilitation services: (i) Department of Health (DoH) as the agency of government in the provision of services; (ii) Health Professions Council of SA (HPCSA) through the various professional boards in guiding and regulating the professions; (iii) Department of Public Service Administration (DPSA) as the agency that employs public officials; and (iv) Tertiary training institutions in the production of rehabilitation personnel. While sector-wide service delivery is also guided by other Departments (e.g. National Treasury, Provincial Departments) in overall public administration, an analysis of the functioning of these four key institutions in the delivery of rehabilitation services provides sufficient evidence of the constraining environment within which policies are required to be implemented.

As provider of health and rehabilitation services to the majority of people with impairments and/or disabilities, the DoH introduced a new policy to guide rehabilitation services in 2000 through the National Rehabilitation Policy (NRP) (4). This required the implementation of a changed agenda from the way rehabilitation services were delivered. National policy calls for the integration of various professions at the point of delivery within the Primary Health Care (PHC) approach. However, evidence suggests that managers at local, provincial and national levels are not capacitated to manage change. Reprioritization and reorientation to PHC means going beyond policy statements by influencing the way services are managed, aligning structures and responsibilities to policy intent, as well as addressing allocation inefficiencies in the broader public health sector to make more resources available to PHC. Together with evidence of the gap between policy and practice, the DoH as the dominant sector in the provision of rehabilitation services has not demonstrated the capacity to deliver effective, efficient or equitable rehabilitation services and has had little impact on moving away from the individual biomedical approach to rehabilitation.

When government depends on the HPCSA to act as an agency to guide the professions, it would be expected that norms and standards set by the professions are also aligned to national policies for effective and efficient service delivery. In the case of rehabilitation professionals, policy imperatives do not concur with professional norms and standards. The NRP calls for integrated rehabilitation services within the social model of disability, while norms and standards as defined by the Council follow an individual and medical approach to intervention. Registration with the different boards, with norms and standards set by separate professional bodies, further deviates from efforts in implementation of policy objectives set by DoH. It becomes apparent that formal institutional arrangements regarding service development (as opposed to professional development) have been neglected for rehabilitation, leaving the 'rules of the game' undefined or unclear, thus perpetuating the incapacities of those expected to deliver services.

DPSA, as an 'employment agency' of government, seeks to ensure that the public sector is an attractive employer of choice among rehabilitation professionals. Issues of remuneration are known to be a major 'push factor' from the public service, but retention policies have not been effective as seen through the declining number of rehabilitation professionals employed in the public sector (5). In the recruitment and retention of rehabilitation professionals, there is an expectation of coherence between policies, guidelines and its related structures to

impact positively on service delivery. Once employed, effective utilization of human resources (HR) within organizations is the most important factor in determining whether public officials are productive or not (6). This is not the case for rehabilitation. With evidence of managerial incapacity and resistance to change amongst rehabilitation professionals, a transformative HR strategy was not available to make public service meaningful and purposeful (7), which could have served as a contributory ‘stay factor’. Attention is needed to make the working environment attractive, both for improving productivity as well as for career development. Promotion into higher level post structures as recognition of further clinical qualifications is not available for rehabilitation professionals. Addressing capacity issues therefore, must move beyond individual performance based on skills and training opportunities, towards addressing broader capacity constraints at an institutional level.

The training of rehabilitation professionals has come under increasing scrutiny in the light of poor outcomes for PwD. Resistance to integration and change as demonstrated by the rehabilitation professionals themselves, is a sign of weakening professional identities. The development of a professional identity starts with the educational process where students are socialized in the values, attitudes and beliefs of their chosen profession and a commitment to a professional career (8). This process continues into the working environment where this identity is tested within a context of diversity and dynamism. It appears that in the educational process of developing professionals, separate socialization processes are not adequately preparing the rehabilitation professions to adapt and further develop core skills and attitudes taught at university for the working environment. Rehabilitation professionals are trained and registered as ‘specialized’ professions for employment in the public sector, while health policies require the rendering of integrated services at the PHC level, once employed. Evidence shows that social work has an identity crisis in terms of its self-perception (9); that occupational therapists and physiotherapists are beginning to display potential for a weakening professional identity (10); and that role ambiguity and uncertainty in relation to teamwork are evident in how they construe their identity. The DoH depends on the different professional boards/associations to maintain a certain technical proficiency. However, regulatory functions and guidance by the professional boards should not be in conflict with policies of the DoH, specifically with the NRP. This is crucial for effective HR performance and service outcomes.

These four agencies are expected to function coherently to deliver effective, efficient, equitable and sustainable rehabilitation services within the public health sector. Instead, they are constraining these services, highlighting the social and institutional phenomena impacting on service delivery.

An analysis of the institutional context has demonstrated how this dimension is impacting negatively on rehabilitation service delivery at every level. Capacity to deliver effective, efficient, equitable and sustainable rehabilitation services requires a paradigm shift to occur concurrently at the Policy & Systems level; Service level and Organizational level, as shown in Figure 1 below. Currently, it has reached a crisis mode, with professional goals in conflict with the administration at the organizational/facility level in improving access and increasing coverage for rehabilitation service delivery. Localized or isolated efforts by managers have little chance of surviving within an institutional context that constrains inter-agency and inter-professional performance within the public sector.

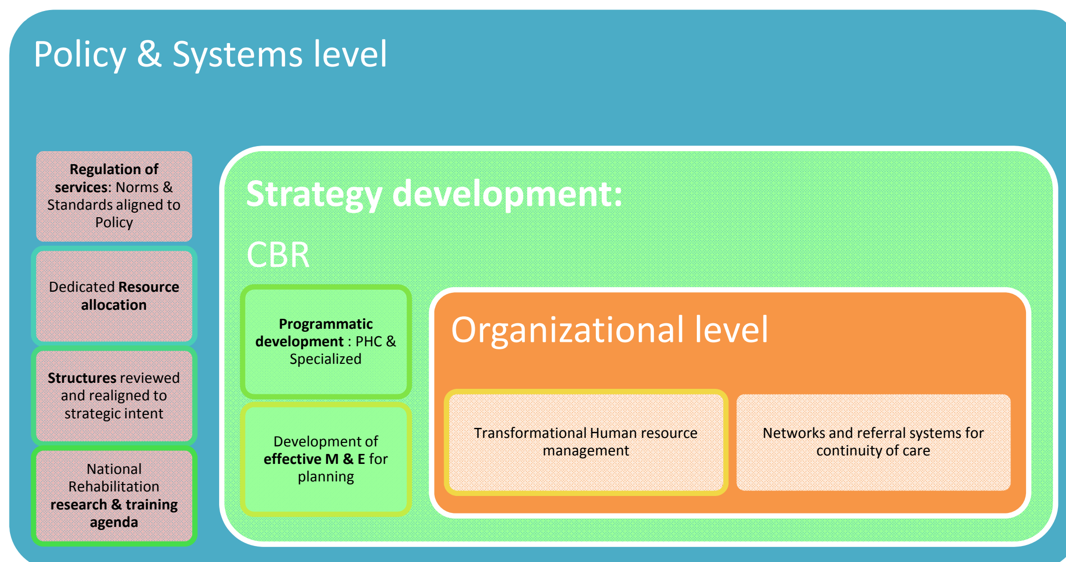

Figure 1. Institutional context to improve rehabilitation service delivery

Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.

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