Letters

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The future of general practice in South Africa

There is a shortage of human resources in Africa but also poor management by governments with poor working environments and career paths in primary care[1] and mal-distribution of healthcare professionals. Post-apartheid South Africa saw black nurses moved out of hospitals dominated by white doctors to 'nurse-driven' district health services, citing 'doctor shortage'. The government has struggled to regulate the private sector that exploded as public hospitals deteriorated and specialists moved in droves to private hospitals. Total healthcare expenditure for South Africa in 2012–2013 was R122 billion for public services for 42 million people, with a private sector spend of R103 billion on only 8.7 million people.

The African National Congress has been championing national health insurance (NHI) since 2008, including GPs as providers. Government has included primary healthcare (PHC) re-engineering in NHI policy since 2011, fashioned around three streams: district specialist teams, school health teams and PHC outreach teams, consisting of two professional nurses, one enrolled nurse, and six community health workers, providing all PHC services, including treatment for 'minor illness', to a defined population of 7660 people.[2] Interim evaluation suggests that this model is struggling with accountability and skills.

The role of the GP has been declining in both private and public sectors. Doctors are not attracted to public sector primary care in clinics where they are meaninglessly 'pushing numbers' as employees and subordinate to nurse managers.[3] Patients bypass clinics to get to doctors in hospitals or visit private GPs. GPs, as doctors just finishing their medical school and setting up shop with no postgraduate training, occupy a threatened space with ageing (mean age 46 years) and declining competencies.

GPs are willing to engage with government capitation at the same cost as the public services PHC.[4] This could be linked to postgraduate training in family medicine and will move many more clinicians into primary care. Government has ample resources, including grants from the European Union and UK, but is reluctant to contract fully with GPs, even in pilots, with the Minister of Health responding, 'How will we monitor them?'. Instead the minister wants to contract doctors to work in public clinics for a few hours a week. Lessons from the UK, to include and incentivise GPs as complete service providers, appear lost. There is a strong need for better primary care in South Africa. Resources are not the real problem, but political will and trust are.

Shabir Moosa,

Family Physician and Senior Clinical Lecturer in the Department of Family Medicine, Johannesburg Health District and Faculty of Health Sciences, University of Witwatersrand, Johannesburg, South Africa.
E-mail: shabir@drmoosa.co.za

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DOI: 10.3399/bjgp14X676997

Suicide risk among farming patients and the effects of HS2

Bridget Osborne's editorial[1] describing the increased risk of suicide among farmers overlooks the effects of HS2 on the mental health of the rural community. The proposal for HS2 marches on despite an enormous amount of doubt from all quarters. Furthermore the technical report from Temple-ERM[2] regarding the health impact has been superficial to say the least, hidden quietly as Appendix 9 of the HS2 Sustainability Statement and with only 29 references. For example there is no mention in HS2 health assessment policy of the suicide risk of farmers, apparently well known to the government through their Suicide Prevention Policy.[3] Surprisingly, according to the health analysis there is no legislative requirement for health impact assessments with these major projects, something which should sound alarm bells in the corridors of medical and public health colleges and the Department of Health.

HS2 will take up to 20 years to complete.[4] The effects of 20 years of emotional, economic and financial uncertainty will lead to mental health issues for many communities. There is anecdotal evidence that rural businesses that supply farmers have already seen a 20% drop in turnover (B Osborne, personal communication, 2013) reflecting farmers' insecurities about their business future.

Furthermore farmers have little reassurance in a fickle and as yet unclear compensation scheme to counteract their hardship. The government has already stated the project has a limited budget and should represent 'best value' for the public rather than supporting farmers and rural communities to the degree of the true financial loss. This merely provides further justification for farmers worries that they will be last in line for any handouts, after consultant and construction costs.

I fear for the mental health of hard working farmers as a result of the economic suffocation HS2 planning is producing on farmers and rural communities, the hidden blight of the 'pre-construction threat' never mentioned in any press release or government statement so far. Osborne refers to the 'ups and downs' of farming. It is likely to be down for a long time in certain parts of central England and the mental health effects will be on the whole of the rural community not just farmers. Public Health should ensure all major projects have a more robust, deeply evidenced and searching analysis of health outcomes.

Alwyn Ralphs,

GP Partner, Wolstanton Medical Centre, Newcastle-under-Lyme.
E-mail: alwyn.ralphs@btinternet.com

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DOI: 10.3399/bjgp14X677004

Will the age of austerity save the NHS?

I have always been a passionate supporter of the NHS and initially viewed the Nicholson challenge as a threat to the future of the NHS; now though I wonder if it may actually save the NHS.

Among the many good things the last government did for the NHS there were changes that have significantly increased costs without improving quality of service. Agenda for change, the working time directive, consultant contracts and GP opt outs for out of hours all improved quality of life for staff, but have not improved health outcomes for patients. Significantly increasing costs without improving outcomes has also reduced productivity. Innovations in patient services, such as walk in centres, NHS Direct and Darzi centres, again driven more by wants than needs, have improved access without improvements in health outcomes. This has come at a time of previously unimaginable advances in quality of life and life expectancy, with the elderly population in some areas increasing by 30% over the past 10 years. A rapidly increasing elderly population with falling productivity will make current NHS provision unaffordable within a generation.

With the population growing and health cost inflation exceeding GDP growth even pre-2008 levels of funding will soon be insufficient without significant structural reform. While it is tempting to let our children worry about this, the crunch point of affordability is coming and if we don't plan for this, we will soon reach a point where a publicly-funded, universal free healthcare system will be unaffordable. Prior to this, health and social care costs will gradually throttle our economy as demand increases.

Depressing though this is, we have the opportunity to avert disaster. Humans have a natural capacity for innovation, and if we can embrace this to evolve our health delivery model we can evolve to one that is sustainable for the next few decades. In times of plenty, changes in public services were often based on wants rather than needs. In the next decade, changes will have to be based on patient needs. As long as the patient is at the centre, selection of only those innovations that improve productivity and improve care, can reshape the way we deliver care for our population in the 21st century. Failure to embrace this change will result in a health system like the US, where only the rich have access to health care.

Rob J Daniels,

Townsend House Medical Centre, Seaton. E-mail: rob.daniels@nhs.net

DOI: 10.3399/bjgp14X677022

Reducing inappropriate A&E attendances

Ismail *et al* clearly show that interventions in primary care do not decrease the number of inappropriate attendances at accident and emergency departments (A&E), nor increase patient self-care.[1] In Belgium (Flanders), we observed a large increase in attendance of young children at primary care out-of-hours (PCOOH) services after implementation of a general practice cooperative (GPC).[2,3] Recently, data from new PCOOH services in colocation with A&E showed nearly identical findings. Patients increasingly use the GPC, while patient fluxes to the A&E remain stable. These observations can be partly explained, because implementing PCOOH services was not meant to improve overall efficiency of the healthcare system, but rather a response to increasing strain on OOH care: lowering numbers of GP equivalents, feminisation of workforce, and decreasing safety during home visits were principal drivers for these changes. From earlier work, we know that patients tend to choose PCOOH services based on their previous experiences and that they like a technical environment.[4] Modest co-payment does not significantly influence health seeking behaviour.[5] Patients do not tend to think in 'primary' and 'secondary' care when in (perceived) need for urgent care. To change patient behaviour, we need well-designed, multifaceted interventions envisaging high quality and sustainable health care, not in response to dissatisfied groups of professionals. This means that professionals and their payers collaborate to establish integrated models of care. In Belgium (Flanders) this would mean structural collaboration of A&E and PCOOH services, and not competition for the majority of the patients. Due to rapidly declining numbers of GPs and medical specialists working in A&E, our professionals seem ready for this. Financial issues of these services need to be tackled as stakes are high for all stakeholders. Raising public awareness about appropriate health services use is of major importance as well.[6] From the BBC Masterchef series we learn nearly every day that good cooking is possible for everyone. However, we did not observe any instructive series on how to deal with urgent needs within our health system.

Hilde Philips,

PhD, Primary and Interdisciplinary Care Antwerp, University of Antwerp, Belgium. E-mail: hilde.philips@uantwerpen.be.

Barbara Michiels, Samuel Coenen, Roy Remmen,

Primary and Interdisciplinary Care Antwerp, University of Antwerp, Belgium.

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DOI: 10.3399/bjgp14X677031

Studying and reducing DNAs to improve access

We originally had a 4-week advance booking system for appointments which we had for over 10 years but were not performing well on 'access' because of a high number of patients who did not attend (DNA). We often had over 100 DNAs per month so many appointments were being wasted. I noticed that another local practice which permitted advance booking only 2 days ahead scored better in the 'access' survey than our practice. Another local practice was piloting a same day booking system with no appointments booked in advance, from June 2013.

We calculated that we had nearly the correct number of GP and nurse appointments per 1000 patients, per week. The Local Medical Committee had advised 100 appointments per 1000 patients per week. We are an average size practice of 6400 patients.

An audit of the DNAs in April 2013 showed that 80% of DNAs had booked more that 7 days previously, so we changed to a 1-week advance booking system from 1 July 2013 with 50% of appointments bookable in advance and 50% available on the day, for GP appointments but not nurse appointments. The 'same day' appointments were unblocked on the day at 8 am each morning to prevent them being booked online.

A repeat audit of DNAs in October 2013 showed that 75% of patients who DNA had booked more than 3 days ahead so we have just changed to a similar 3-day booking system from Monday 9 December 2013. This has reduced our DNAs and reduced stress within the practice. Other practices in the UK may wish to consider these ideas. I have concluded that a 2–3 day advance booking system is the right one for our practice and will probably be optimal for most practices.

Mohammed N Hossain,

Senior Partner, Stanhope Surgery, Waltham Cross.
E-mail: mohammed.hossain@nhs.net

DOI: 10.3399/bjgp14X677059

Predictive validity of selection for entry into postgraduate training in general practice

The recent paper by Patterson *et al*[1] reports the encouraging and considerable predictive validity of MCQ (CPS 'clinical problem solving') and situational judgment test (SJT) selection tests for performance on the two MRCGP formal examination components.

The MCQ and the SJT correlate with the Applied Knowledge Test (AKT) at 0.85 and 0.69, respectively (range-corrected). From data provided in the paper, together the two selection tests can be seen to predict 74–75% of AKT score variance. The two tests also correlate with the old-style Clinical Skills Assessment (CSA: 0.55, 0.57, respectively, range-corrected). Together they predict 37–38% of CSA Score variance. But the subsequent Selection Centre (SC), then a three station OSCE and correlating with the CSA at 0.41 (range corrected), is reported as only explaining an additional 2% of CSA score variance.

Given that a set of computer-delivered multi-choice tests will cost £100–200 per candidate and that the true cost of a selection centre will be at least £1000, the latter seems to provide relatively very poor value, especially with about 5000 candidates being shortlisted for selection in 2012.[2] Perhaps the £5 million-plus could be better used in supporting poorly-performing trainees?

Also, those of us who are responsible for devising OSCE assessments would be grateful to learn how one with three stations, single marked, can be devised such that its reliability (Cronbach's α) is 0.87, when considerably longer similar assessments give far lower reliability estimates; for example, MRCGP CSA (13 stations) 0.77,[3] and iMRCS Part B (8 station subtests) 0.68–0.72 and (10 station subtests) 0.76–0.78.[4]

Richard Wakeford,

Hughes Hall, University of Cambridge, Cambridge. E-mail: rew5@cam.ac.uk

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DOI: 10.3399/bjgp14X677068

Why study?

In November's *Out of Hours*, Trisha Greenhalgh asked the rhetorical question 'Why study?'.[1] Her reflections were prompted by one of her self-funded, mature students completing his PhD while studying part-time and working as a full-time clinician.

She answered her own question by suggesting academic study resulted in both a public good and a benefit to the individual undertaking study for its own sake. As the student referred to in her article, perhaps I can provide a perspective on the personal benefits of academic study.

After approximately 25 years of non-academic full-time clinical practice, I felt at a crossroads. I wondered what I was going to do with the rest of my life. Clinical practice can be immensely fulfilling but it can also become mind-numbing under the pressure to care for a seemingly unending stream of patients.

Academic study provided an opportunity for me to pause, reflect on, and understand my experience within a larger context than my own practice. I found it immensely satisfying to think about 'big ideas' and academic study provided an opportunity to do so.

A structured programme of academic study produced many side benefits. It increased my self-confidence and self-esteem. My information searching and retrieval skills, improved. My ability to write coherently without resorting to wild hyperbole continues to develop. Even my spelling improved. Academic study changed both my way of thinking and approach to problems. I learned to evaluate how arguments are constructed, consider evidence used to justify assertions, recognise rhetoric, and most importantly I learned to be sceptical and not to accept conclusions at face-value.

Academic study requires considerable investment of time, energy and money. Having the opportunity to observe full-time academics for the past decade made me realise I do not want to be one. For me, the main reason for prolonged academic study was personal fulfilment. So, for the time being I plan to continue my clinical practice and remain a hobbyist researcher. I now realise there are many opportunities to do meaningful research on a shoestring budget or no budget at all. I look forward to many more years having more fun doing this!

Don Eby,

Emergency Department, Grey Bruce Health Services, Owen Sound, Ontario, Canada. E-mail: d.eby@sympatico.ca