Letters

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 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 7640 people. 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. 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 capitulation at the same cost as the public services PHC. 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.

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 Suicide risk among farming patients and the effects of HS2

Bridget Osborne’s editorial1 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-ERM2 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.

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Reducing inappropriate A&E attendances

Ismail et al clearly show that interventions in primary care do not decrease the number of inappropriate attendances and why. They get rid of the emergency departments (A&E), nor increase patient self-care. In Blandford, they observed a decrease in attendance among young children at primary care out-of-hours (PDOC) services after implementation of a general practice cooperative (GPC). Recently, data from new PDOC services in colour 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 PDOC services was not meant to improve overall efficiency of the healthcare system, but rather a response to increasing strain on OOH care: lowering health seeking behaviour. Patients do not like a technical environment. Modest co-payment does not significantly influence health seeking behaviour. Patients do not tend to think in primary care: low cost, universal free healthcare system will be unsustainable. Prior to this, health and social care costs will gradually erode until the current system is no longer affordable and coming in if we don’t plan for this, we will soon reach a point where a public-funded, universal free healthcare system will be unsustainable. Prior to this, health and social care costs will gradually erode until the current system is no longer affordable. Putting pressure on the NHS to improve quality of life is daunting. Humans have a natural capacity for innovation, and we can embrace this to evolve our health delivery model. We can evolve to an environment 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, solution of only those innovations that improve productivity and improve care, can reshape the way we deliver care for our population in the 21st century. I am sure that this embracing this change will result in a health system like the US, where only the rich have access to health care.

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References

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 and many appointments were being wasted. I noticed that another local practice which permitted advance bookings with a co-payment factor scored better in the assessor’s view 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 patients and nurse appointments per 1000 patients per week. The Local Clinical Committee had advised 100 appointments per 1000 patients per week. We are an average size practice of 6400 patients.

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

The recent paper by Patterson et al reports the encouraging and considerable predictive validity of MCG (CPS clinical problem solving) and situational judgment test (SJT) selection tests for performance on the two MRCP general examinations. The MCG and the SJT correlate with the Applied Knowledge Test (AKT) at 0.85 and 0.83, respectively. Range-correlations with the objective structured clinical examinations were 0.76 and 0.71, respectively. The two tests also correlate with the old-style Clinical Skills Assessment (CSA: O35, O37, respectively) range- corrected. The data included 5488 candidates who provided the data. The two tests correlate with the CSA Score variance. But the subsequent Selection Centre (SC), then a three-stage OSMC and correlating with the CSA at 0.41 range-corrected. It 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 £1800, the latter seems to provide relatively very poor value, especially with about 5000 candidates being shortlisted for selection in 2014. Perhaps the 50 million plus could be better used in supporting poorly-performing trainees?

Also, all of us who are responsible for devising OSMC assessments would do well to learn how one with three stations, single marked, can be devised such that its reliability (concurrent, construct, and the true cost of a selection centre will be at least £1800, the latter seems to provide relatively very poor value, especially with about 5000 candidates being shortlisted for selection in 2014. Perhaps the 50 million plus could be better used in supporting poorly-performing trainees?

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