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 move 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. 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 capitation 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 editorial 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 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. 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. 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 do not reduce DNAs and stress within the practice. They also show that introducing web-based urgent care advice would improve on telephone advice and would be optimal for most practices. Other practices in the UK may find it beneficial to change to a similar 3-day booking system from 6 am each morning to prevent them being booked online.

Most studies of DNAs in October 2013 showed that 75% of patients who DNA had booked more than 7 days previously, so we changed to a 1-week advance booking system from 1 October 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 unlocked on the day at 8 am each morning to prevent them being booked online.

The reported improvement of DNAs in October 2013 showed that 75% of patients who DNA had booked more than 3 days after so we have just changed to a similar 3-day booking system from 6 am each morning to prevent them being booked online. We reduced our DNAs and reduced stress within the practice. Other practices in the UK may wish to consider these ideas. If we 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.

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Will the age of austerity save the NHS?

I have always been a passionate supporter of the NHS and I 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. Falling productivity has significantly increased costs without improving outcomes. Innovations in patient services, such as walk in centres, NHS Direct and 111 centres, again driven more by wants than needs, have improved access without improvements in health outcomes. This has come a time of unprecedented rapid 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 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 erode until demand increases. Depressing though this is, we have the opportunity to avoid 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. The 21st Century will see our health system evolve and this change will result in a future health system like the US, where only the rich have access to health care.

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Studying and reducing DNAs to improve access

We originally had a 6-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 performed advanced appointment booking had reported 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 nurse appointments and nurse appointments per 1000 patients, per week. The Local Medical Committee had advised 180 appointments per 1000 patients per week. We are an average-size practice of 6400 patients.

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Why study?

In November’s Out of Hours, Trishca Greenhalgh asked the rhetorical question Why do researchers waste time, resources and funding, prompted by one of her student-funded, mature students completing his PhD while studying part-time and working as a full-time clinical GP? She asked her question by suggesting academic study resulted in both a public good and a benefit to the individual but to do so in order to earn its own sake. If 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 wanted to do with the rest of my life. Clinical practice can be immensely fulfilling but it can also become mind-numbing under the pressure for care to seem 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. I found the intellectual stimulation of academic study produced many side benefits. It increased my self-confidence and self-esteem. My writing and research skills improved. My ability to write coherently without resorting to wild hyperbole continues to improve. My personal research skills improved. Academic study changed both my way of thinking and approach to problems. I learned to think about ‘big ideas’. I continued to 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 and not to accept conclusions at face-value.

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