

Public sector district health system: Is seven to ten minutes enough for patient management?

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Summary

This paper looks at the reasons for the excessive workload of grass-root and primary health care physicians at the Mitchell's Plain Community Health Centre in the Cape Town Metropolitan (CTM) South (Mitchell's Plain) district in South Africa. The development of a municipality based district health system has created an opportunity to practice family medicine in Mitchell's Plain, but lack of clinical time to practice family medicine in the current setting raises questions about the quality and efficiency of primary health care in the municipality based district based health system. To prevent the situation from developing into a 'Diseased District System!', enough clinical time and dedicated resources are urgently required.

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Introduction

The municipality based district health system is a newly developed approach of the District Health Systems (DHS) to provide comprehensive primary health care to the communities in one or several districts in the city's municipalities, as part of the national health system of South Africa. The aim of the DHS is to promote primary health care services with the full integration of all existing services and the

most efficient use of scarce resources under the management of a District Health Management Team (DHMT), governed by the district health authority (DHA).² This development seeks to integrate all the components of comprehensive health care (promotive, preventive, curative, rehabilitative and palliative) and the activities of other sectors such as education and welfare, in accordance with the broader needs of the community.³ However, public sector primary care

providers are facing overwhelming demands for curative services which lead to missed opportunities in the preventative field. Unless protected time and dedicated resources are provided for prevention in the developing DHS, it may become a Diseased District System!¹

Characteristics of a DHS

Some of the characteristics of DHS are:⁴

- A defined catchment area, i.e., it

will provide service to residents living within a specified boundary (in a district, either in a municipality in a city or in a province);

- All health services within the demarcated area will be part of the district health services;
- District health services will comprise community-based services, mobile clinics, community health centres and some district/community hospitals.
- Important principles of the DHS include decentralisation of responsibility and overcoming the present fragmentation of the services for provision of quality health care.⁴

Prevention opportunities missed

The most important clinical duty in primary health care is consultation with patients and communication with their support system. Although the demands for curative care are very high, in communities, the primary care provider has a responsibility to recognise prevention opportunities, apart from caring and healing. Consultation goals in primary health care should therefore find a balance between curative and preventative care with clinicians combining opportunistic health promotion and diseases prevention with their conventional task of diagnosis and management of health problems⁶ during consultations. They may use the model for assessing psychosocial problems (MAPP)⁷ in family medicine with necessary biological assessments. The greatest single fault in primary care consultation is probably the doctor's failure to allow patients to describe their problems fully. The consultation is usually dominated by the doctor asking only certain questions, or else the patient is not given enough time to talk.⁸ This may shorten the interview, but may be false economy because the patient may keep returning because of unresolved

problems. A patient usually assesses the doctor quite early in a consultation. If the doctor really listens and shows genuine interest, the patient may ask for preventative help. One study⁹ in the Cape Metropolitan area found that opportunities for antismoking education are often missed when patients attend Community Health Centres (CHC's). In brief consultations, patient concerns usually remain unresolved and preventative care is absent.¹⁰ In the United Kingdom, a functioning consultation time in primary health care may range from 1.55 to 14.80 minutes (Byrne and Long 1976).¹¹ Others found that average consultation time in general practice is about eight minutes although there are moves to increase this to ten minutes as the list of patients decreases. It can even be prolonged to more than 15 minutes.¹⁰

To discuss the of necessity and availability of clinical time at primary health care centres in the South African DHS, we need to compare it with the time available to a primary care physician per patient, given existing resources. Insufficient data in South Africa precludes comment on this issue.

On the other hand, a model of district-based primary care services has been tested in Tafelsig Community Health Centre (CHC) in the Mitchell's Plain (MP) in the Cape Metropole. Tafelsig CHC was established in 1994 by the health department of the City of Cape Town specifically to develop a model of a comprehensive service. The health department of this local authority runs five other clinics/CHC's in the Mitchell's Plain's district and usually provides selective preventative services as a vertical program (developmental screening for neonates, immunisation of children under five, family planning, treatment of communicable diseases such as, tuberculosis and

sexually transmitted diseases). Curative health services were previously delivered separately by the MP-CHC of the Community Health Services Organisation (CHSO) of the Provincial Administration of the Western Cape (PAWC). The City of Cape Town did not have previous experience of providing general curative services.

After the introduction of curative services for all, Tafelsig CHC⁵ has documented that:

- As a result of an unlimited and growing demand from the community for curative services, an appointment system for the 40 000 residents of Tafelsig had to be developed, with burn-out threatening staff at the CHC.
- Curative care demands have made it difficult for staff to maintain high standard of preventative care.⁵

This raises concerns regarding the needs, opinions and inputs of patients, grass root health care workers and community organisation, which was not discussed in the Blecher and Frankish approach to the district based health system.¹² This approach⁵ did not consider the outcome for patients who did not receive quality preventative care and did not address the necessity for holistic patient care. In fact, people from Tafelsig who were turned away because of the unlimited demand for curative services, started attending the MP-CHC's day- and after hours service in the same health district. This MP-CHC is the only other comprehensive CHC in MP. Thus the success of the district based health service of Tafelsig CHC will depend on the success of MP-CHC. Now Mitchell's Plain, Tafelsig CHC, and other clinics will come under the CTM South (Mitchell's Plain) district; which is one of the four health districts of the City of Cape Town Metropolitan Local Council. This will be called a municipality-based new district health system.

Description

Against his background it is appropriate to look at the clinical time available for medical officers in the Mitchell's Plain CHC in the developing (municipality based), district health system of South Africa.

Since the presentation of the White Paper on the transformation of the health system in April 1997, the PAWC's provincial health department has introduced the primary health Care (PHC) approach of the district health system, leading to the decentralisation of a number of services from tertiary and secondary to primary level. This has increased workload of the Mitchell's Plain CHC. Factors related to the increased workload are multi-factorial and inter-related but can be divided into the following categories:

1. Availability and type of health facilities

MP is a township with total population of approximately 700,000, mostly disadvantaged people of mixed descent.

- Built in 1986, the township provides a wide range of basic curative health services and serve as a referral point to secondary and tertiary hospitals. Up to 1993, it was operating as a day hospital from 8:00 to 17:00. From 1993, the hospital continued to provide curative services, including 24 hours trauma and emergency. From 1997, it became part of the integrated and comprehensive DHS. Communities were instructed to attend the CHC for health problems and not secondary and tertiary hospitals without a referral from the CHC.
- Nine to ten medical officers are available daily for patient consultations. One medical officer on weekdays, and two on weekends

and public holidays are allocated to trauma and emergency duties.

- Presently the MP-CHC has insufficient hospital support. As part of a DHS, Mitchell's Plain community should have access to a hospital, but there is no hospital in this district. Only complicated emergency cases can be referred to the G.F. Jooste emergency hospital, 20 km's from the MP-CHC and situated in another health district. It is the only emergency secondary hospital for three health districts on the Cape Flats and does not have a specialist out patient service for chronic complicated cases. The referral support system is clearly inadequate.

2. Effects of the developing DHS

Since 1997 PAWC has

- downscaled and closed the general out patient department of the Red Cross Children's Hospital, and children under 13 are now attending primary level¹³ community health centres;
- incorporated previously vertical programmes into the primary health care packages that include school health, oral health, reproductive health, geriatric, midwifery and obstetric health services, resulting in more people are attending the CHC's for their needs. As the district surgeon system is phased out, more jobs will be given to the CHCs.¹⁴
- Increased referrals of chronic cases to CHC's and closed numerous beds in teaching hospital¹⁵. Prolonged waiting for appointments with doctors at secondary and tertiary level results in more visits and a patient backlog at primary health care centres.
- Medical officers are often required to dispense medicine due to lack

of pharmacists and after hours pharmacy closure.

- Free primary health care resulted in more patient visits to the primary health care centre.
- Psychiatric health services were integrated into the CHC's. Patients needing admission for an acute psychiatric conditions must be discussed telephonically with the receiving psychiatric hospital doctor on a compulsory basis (only a letter is not enough). Development of the DHS requires the help of medical officers, increasing the work load of other medical officers.
- Termination of Pregnancy (TOP) procedure and the Prothrombin Index (PI) were incorporated into the MP-CHC.

3. Socio-economic factors

Worsening socio-economic and biopsychosocial factors have led to increased –

- violence and gangsterism
- high rates of unemployment.
- attendance for completion of unemployment benefit forms
- attendance regarding new disability grants and renewals
- teenage pregnancy
- single parent households
- smoking, substance abuse and alcoholism
- vehicle accidents as a result of drugs and drunken driving
- attendance for completion of Multilateral Motor Vehicle Fund (MMF) forms
- marital disharmony, divorce and dysfunctional families
- domestic violence, rape and abuse of children and women
- psychiatric illnesses
- sports related injuries
- STD's, HIV infections and AIDS
- environmental hazards and threats
- refugees

- drug overdoses
- tuberculosis

4. Poor management and administration

Poorly organised records and patient information MP-CHC hinders the smooth flow and efficiency of patient consultations. Due to the absence of clinical nurse practitioners, primary care clinicians in MP-CHC are the medical officers.

No internal audit involving the whole team has been done on any disease in the MP-CHC. Time constraints, absence of a collaborative approach and the other consequences of large patient loads affect the care of patients with diabetes¹⁶ and implementation of guidelines for the control and management of diabetes and hypertension by the primary health care professional at CHC's.^{17,18}

5. Co-related factors

All factors above contribute to an increased patient load at the MP-CHC without an increase in the number of doctors during the day and after hours. Apart from trauma, surgical and medical emergencies, doctors in the emergency unit have been given many other responsibilities, including:

- certification of DOA patients
- completion of death certificates¹⁹
- assessment for mental certification of patients brought in by a police officers
- attending to patients brought in from police custody.
- attending to work injuries and completion of first medical report forms
- completion of J88 forms for abuse and trauma cases

Despite an alarming population increase in Mitchell's Plain and increased responsibilities as a result

of policy changes, this CHC has not expanded its resources and operates far beyond the capacity for which it was designed and built in 1986. Patients are turned away daily even though one medical officer sees an average of 40/45 patients during 8-hour working day. These patients return after hours, thus increasing the workload of the after hours trauma unit. Despite a continuous triage after hours, every patient is issued with a folder and if the patient is turned away, findings must be recorded in emergency as well as non-emergency cases.

Staff are subjected to high levels of patient pressure and demands.

Discussion

From the above it is clear that more and more curative services and consequently fewer preventive services, are provided by the MP CHC. With significant psychosocial needs; patients from the MP community need empathy, support, and interaction with families without immediate referral, to prevent them feeling misunderstood by the primary care physicians. Many have problems that cannot be solved with a simple prescription, but can be managed in the PHC setting. To manage the needs of this community, primary care physicians need to practice family and community oriented primary care with a patient-centred approach. An opportunity to do this, has been created by the restructuring of the health services based on district health system with its primary health care approach.

However, a medical officer at Mitchell's Plain CHC trauma and emergency department sees 35 to 40 patients per day. In non- or semi-emergency situations, he/she consults forty five patients (from 08h00 to 16h30 including tea break and lunch).

The question arises whether six to

seven minutes for a non-emergency, and eight to ten minutes for an emergency patient are enough?

Duties of family physicians at the CHC include consultations with patients, but also patient examinations, medical procedures, X-ray procedures, prescriptions, completion of forms, scheduling appointments, writing referral letters, recording patients information and other tasks to improve 'continuity of care'. Against this background it is clear that comprehensive primary health care management of a patient in the MP CHC requires a consultation of ten minutes or longer, while other tasks require at least five minutes or longer – in other words, total clinical time of 15 to 20 minutes for each visit.

With present resources, the development of the DHS and clinicians' excessive service load, the lack of availability of clinical time poses a serious threat to the quality of service provision, especially with the DHMT continually wanting to increase patient numbers without considering quality of the management. This is creating a tendency to treat patients as numbers or objects.

If these trends continue, the development of a successful municipality based district health system with the integration of comprehensive primary care could be severely compromised.

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HOW TO CUT THE COST OF YOUR DSTV WITH MMTV

Tuesday, 29th January 2002, saw the introduction of a new subscription medical television service, Matters Medical Television, (MMTV) that broadcasts lectures to doctors on alternate Tuesday nights at 8.00 pm. Mark Hopley, from the Department of Medicine at Chris Hani Baragwanath Hospital, delivered an excellent talk on the diagnosis of Tuberculosis in South Africa. Since then six further broadcasts have covered Obesity, Food Allergy, Glomerulonephritis, Hazards of Long Haul Air Travel, Malaria and Breast Cancer. Each topic has been covered by an authority in the field and has been well received by viewers throughout the country.

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Matters Medical offers all doctors a free preview programme where they can earn a CPD point and evaluate the service. Doctors are urged to take advantage of this opportunity while it is still on offer. The programmes are prepared in consultation with the Department of Family

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