People and Health

P. E. S. Palmer

Feeling unwell?—Must you go straight to hospital?

If people ignore the primary level and go directly to hospital when they are ill the health care system becomes overburdened at the higher levels, inefficient, and unjustifiably expensive. The most effective way to persuade people to use the first level of care is to ensure that its services are reliable and its facilities as attractive as those of the referral levels. Financial incentives aimed at encouraging respect for the system can also play a part.

A health care system should be a pyramid, with diagnosis and treatment of the commonest illnesses forming its base. Most ill health can be treated in relatively simple facilities by staff who have had basic training. It may not be necessary for a sick person to see a specialist or even a physician, but there should be access to a trained health professional for reasons of both health and the efficient working of the system. Patients tend to think they are more ill than they really are, and may wish to consult a physician because of what they perceive as her or his superior abilities and technological backup.

Quality in primary care

How can patients be dissuaded from taking short cuts through the system and thus overloading the chain of facilities leading to the large hospitals? In general, if patients are satisfied with the treatment they receive near home they will not seek help farther afield the next time they are ill. However, it is unreasonable to expect people to return to a primary health centre if they have had poor experiences there.

The first requirement, therefore, is that primary health centres be well staffed and as efficient and pleasant as possible. The cost of achieving this is small compared with hospital costs. It is important to reassure patients that there is an efficient link between the primary health centre and the
first-referral hospital; they should know that, if necessary, they can be rapidly referred.

On the other hand, patients soon realize what is happening if too many people are being referred for minor illness because the primary centre is not doing its job properly. They then tend to bypass the health centre and go straight to hospital to save themselves time and trouble. They are confident that whatever they need is available in the hospital. If there is no trust between patients and the primary health centre it is almost certain to be decreasingly used.

The base of the health care pyramid therefore has to be strong. The buildings may be small and simple but this does not mean that the clinic can be neglected, as it is the very basis on which the hospitals function. If the primary health centre does not attract patients the first referral hospital becomes swamped with cases that are not truly its responsibility. Administrators should realize that the provision of good primary care eventually saves money because hospitals cost more than clinics.

Primary care clinics should be adequate in number and close to population centres. In rural areas, excessive distance between people’s homes and the nearest hospital should not be used as a means of persuading them to visit a primary health centre as their initial step in seeking help. They should go to their local clinics because they know that they are well staffed and well supplied, wherever they are, and offer both good primary care and rapid referral. Patients who go directly to hospital often do so after their illness has reached an advanced stage; in the long run it costs more to cure them than if they had been diagnosed and treated nearer their homes and at an earlier stage. Furthermore, important as the individual is, public health also has to be considered: patients who wait too long before seeking help may spread infectious disease among relatives and friends.

It should be remembered that it may be less costly to operate two small clinics for three days a week each, using the same staff, than one larger clinic serving a wider area. The cost of transporting staff between the clinics may be less than that of having too many patients coming at late stages of illness and needing hospital care.

Personal incompatibility

Some patients may not like the local health care provider. Others may feel that a local person cannot possibly know enough or cannot be trusted to maintain confidentiality. On the other hand, some patients fear strangers and consequently prefer to consult people they know; this problem can be overcome if a permanent local person works with colleagues who stay

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for short periods. Such an arrangement is also valuable in providing opportunities for training and experience among hospital staff, who ought to become acquainted with primary care throughout the district they serve. This can be done by exchanging a clinic nurse or health provider with a worker from a first-referral hospital. The primary care service is thus kept up to date and in touch with the hospital. Such rotation should be made by mutual
agreement wherever possible, rather than by ordering people to move to new workplaces. It is not wise to insist that primary health care providers come from distant places or distinct ethnic groups, since there

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may be customs, fears and attitudes in the community that incomers do not understand. This is not only a matter of language, but of culture in the widest sense.

**Transport**

Referral from a primary health centre to a hospital often requires that transport be provided. Giving patients a note to a hospital and telling them how to get there does not lead to trust. The primary health care centre should take responsibility for arranging transport to and from the hospital if necessary. It is equally important that referral should not be a matter of routine but the outcome of a careful review of the patient at the primary health centre. The hospital should ensure that the patient can return home and that he or she has a note to the primary health centre for further care.

**Monitoring supplies**

Pharmacies and local medical stores, which are often based in or near hospitals, should not forget their responsibility for supplying clinics with essential items. Orders from primary care clinics, which should be given special attention, often provide significant epidemiological information. An unusual increase in the demand for a particular item may lead to a visit from a medical officer to find out what is happening. Is the local nurse or health care provider overprescribing or does he or she face an epidemic and need help? If a primary health centre has prompt and thoughtful support from the first referral hospital, people soon realize that they can get what they need near home and that there is no reason for them to go to the hospital. Such support can be shown in many different ways; it should certainly not be purely verbal.

**Fees**

Although an excellent primary health centre helps to limit self-referral, it does not prevent it entirely and other restraints are necessary. In general, health care that is completely free to patients costs a great deal of money, largely because of overuse and misuse. Many countries have consequently applied a financial brake, patients having to make a payment if they can afford it. Charges on a sliding scale can persuade patients to go to the least expensive clinic for their first visit. Moreover, if a significant proportion of the fees charged is channelled to the local health system, their efficient collection is encouraged and a source of income is provided which is related to the quality of care. The greater the number of patients helped, the larger is the income available for use by the district health committee.

The district committee should ensure that every part of its system benefits from the fees collected and that some of the money goes to primary health centres. Fees are not likely to be collected properly or considered beneficial if they go to the ministry of health. Local involvement in primary health care clinics and first-referral hospitals should
be encouraged. These institutions need funds for a wide variety of purposes, some of which may not seem essential. Primary care centres need support just as much as hospitals, and it is important for the staff at these centres to feel wanted and to receive local backing. Simple actions by the district health committee, such as the provision of paint so that the community can redecorate its clinic, help to ensure that the health centre is considered important locally.

The collection of a standard fee at all health units will not alter the pattern of self-referral. Fees should be on a sliding scale with the charge for a visit to the primary health centre being significantly the lowest. If the patient is properly referred to a hospital the fee should then be less than that charged to people who go without referral. Of course, people suffering genuine emergencies should not be penalized; nor should those who return on planned follow-up visits.

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Where appropriate, staff in first-referral hospitals should refer patients back to primary care clinics. This may be just as good for the patients as further attendance at the hospitals, and is much better for the health service. However, if hospital doctors and other staff feel that conditions in the clinics are bad, this course of action may not be recommended. Hospital doctors should get to know the clinics in their area, and deliver constructive criticisms to the district health committee if there are major defects. It may help if the doctors are given some responsibility for one or more clinics. This does not mean that they should know these clinics alone; they ought to visit and familiarize themselves with all the health centres in their region.

A negative system will not work: if a penalty is imposed on patients who disobey the rules it causes resentment, may produce disruption, and at the very least makes patients delay in seeking care or sends them to districts where they perceive a less hostile approach. Nor is mere counselling or exhortation effective. If the foundations of the pyramid are insecure the higher levels are sure to be even more unstable. In many towns and cities there are large hospitals that are overwhelmed because they have become the only sources of health care. The solution is not to enlarge them but to provide primary care with more staff and space in the community. It is less costly, easier and much more satisfactory to provide primary health centres as long as they have the same status as hospital units. For example, if it is possible to afford a particular piece of furniture for a hospital outpatient department, the same item can just as well be designated for a primary care centre and may be put to better use there. There should be no difference between hospital outpatient clinics and health centres in the quality of their equipment. If hospitals have superior equipment it acts as a magnet to patients and undermines the community health service.

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If primary health centres are well equipped, and if there is a little financial persuasion, patients generally prefer to use them rather than to travel to hospitals. The community should consider the health service as a whole. Primary health centres should be regarded as an extension of hospital outpatient departments, an essential part of a service providing a uniform standard of care. In the long run, only this can
discourage patients from going directly to hospitals.

In addition to practical measures such as the redistribution of money, the upgrading of equipment and the training of staff, there have to be major changes in outlook requiring time, understanding and commitment from all concerned. Hospital staff cannot be expected to change their outlook if primary care facilities and support are not upgraded; equally, the provision of improved facilities is likely to be fruitless if there is not a philosophical realignment and improved professional support.

I believe that the most effective way to obtain the desired results is through persuasion. Locally available health care of high quality is the best guarantee that people will refrain from going straight to the first-referral hospital.

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Children’s teeth have fewer problems

Caries status has improved greatly in most industrialized populations over the past two decades, and this trend has profoundly changed the basic philosophy of caries control. In the early 1970s, the mean number of decayed, missing and filled teeth in 12-year-old children was often as high as 9 and even higher in some populations. In a number of industrialized countries, these figures have now fallen below the “global goal for the year 2000” of 3 or fewer teeth.

However, mean figures of decayed teeth for whole populations frequently obscure the fact that many children at this age are now either caries-free or have only one cavity, and that a small number of children with many cavities contribute disproportionally to the mean values. In this changed situation, frequency distributions, e.g., the percentage of subjects who are caries-free, the percentage with one cavity, or the percentage with more than five cavities, provide better monitoring of changes and risk groups than the single mean number of decayed, missing and filled teeth for the age group.