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Continuity of care and health sector reform

A study of continuity in Cape Town

Community Health Centres

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Abstract

Rising health care costs, the increasing demand for health care and the growing chronic disease burden are factors underlying the need for health sector reform. Continuity of care, an important element of primary care, is associated with goals of health sector reform such as reduced costs and improved health outcomes.

This study sought to determine: i) the extent of continuity in Cape Town public sector clinics; ii) patients' views of continuity; iii) senior managers ideas of how continuity can be improved; iv) clinical managers' views of a proposed practice team model to improve continuity.

Continuity, defined as present if patients saw the same doctor for at least 80% of visits in a 2-year period, was present for less than 9% of patients. Nearly 16% saw six different doctors and 73% more than 3 different doctors, yet 92% preferred seeing the same doctor. Only 40% of the patients reported that a doctor had ever expressed the wish to see him / her at the next visit. 35% of the patients had consulted other primary care services; 86% of these were with private practitioners.

Patients want to be known by their doctor. They are frustrated at having to explain the same problems repeatedly and experience problems when different doctors are seen at consecutive visits. Patients regard the doctor-patient relationship as important and believe that continuity leads to better care.

The top five ways to improve continuity listed by senior managers were: planning work schedules with continuity in mind; developing an effective appointment system; improving human resource management; improving administrative support systems and conducting clinical audits.

In line with evidence from the literature and previous reports on the organisation and management of the clinics, forming small practice teams in large clinics is proposed. Clinical managers believe that this is worth trying and offered ideas on team composition, leadership and implementation.

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CHAPTER 1

INTRODUCTION

Patient care and health sector reform

The demand for health care is outstripping available resources worldwide and driving the need for health sector reform in both the public and private health care sectors. Factors leading to resource constraints include the expansion of social services, rising health care costs and the inefficient use of scarce resources.^{1,2} The shift in the burden of disease from acute infectious diseases toward chronic diseases of lifestyle is adding to the rising costs. These trends necessitate a critical scrutiny of the effectiveness of health care delivery.

Health sector reform (HSR) emphasises the macro elements of health care delivery such as decentralisation and alternative health care financing mechanisms. The micro-elements involved in personal health care receive less attention from health policy makers and researchers. Starfield has shown that practicing four essential elements of primary care – good first contact, continuity of care, comprehensive care and co-ordinated care - reduces costs, increases satisfaction and improves health outcomes.³ There is also evidence to suggest that continuity of care reduces inequities in health care delivery.⁴

At this sharp end of health care the failure to curb known inefficiencies and to use proven cost-effective interventions is manifest. Maynard and Drummond argue that if inefficient medical practice were eliminated, rationalising would not be necessary.⁵ Tudor Hart noted this years ago when discussing the management of hypertension:

(These) failures to deliver the effective care already available represent the main opportunity for rapid advance. Cost effectiveness studies in the USA have shown that investment in improving the adherence of both doctors and patients to planned treatment programmes (mainly by increasing the time given by care-givers to personalising care and adapting it to the individual patients own set of problems) is likely to yield a higher return at lower cost than any other measure.⁶

Cost-effective primary care

Primary (medical) care is considered the backbone of a rational health care system. Improving the delivery of primary care interventions known to be effective is perhaps the main opportunity to reduce costs and improve outcomes. The outcomes associated with the four elements of primary care identified by Starfield are similar to the goals of health sector reform: equity, efficiency, quality, sustainability and acceptance in the provision of health services.⁷ The four elements are also synonymous with key principles of family practice and therefore point to an important role for family practitioners as primary care specialists. The World Health Organisation and World Organisation of Family Doctors (WONCA) take a similar view in the preamble to their 1994 joint working paper:

The family doctor should have a central role in the achievement of quality, cost effectiveness and equity in health care systems and must integrate individual and community health care.⁸

The role of continuity of care

Continuity of care has been defined as medical care, over time, provided by one health care worker regardless of the presence or absence of specific pathology.⁹ The Royal College of General Practitioners defines a general practitioner as one who provides personal, primary and continuing medical care to individuals and families.¹⁰ Continuity of care is considered the most important principle of family practice.¹¹ A growing body of research provides evidence for the positive outcomes associated with the practice of continuity of care. The absence of continuity results in fragmented and episodic care and is associated with unnecessary investigations, inaccurate diagnoses, inappropriate treatment and the wastage of resources.¹² The importance of patient choice and the right to continuity are increasingly being recognised. The South African Patients' Rights Charter¹³ states: 'No one shall be abandoned by a health care professional worker or a health facility that initially took responsibility for one's health.' While this does not necessarily imply individual continuity, it affirms an ongoing relationship with a health service and a health professional as a patient's right.

A longitudinal relationship is the basis of a health care partnership and therapeutic relationship between the health professional and the patient, family and community. It enables health professionals, over time, to build an important database of clinical, personal and contextual information on the patient and family. Such information is needed for accurate diagnosis and treatment - especially in primary care where personal and contextual factors play a significant role in health, illness and recovery.

The Cape Town primary care context

The South African health system faces many challenges. Among these are rising health care costs, the need to expand health and social services to redress historical inequities and the increase in the chronic disease burden. HIV/AIDS now constitutes the biggest challenge, with some services being overwhelmed by the large numbers of HIV-infected patients needing care.

In the Western Cape Province of South Africa, the Metro District Health Services (MDHS) (formerly known as the Community Health Services Organisation) is the provincial (public sector) health authority responsible for most of the primary care services. In the Cape Town Metropole these services are concentrated in 51 community-based clinics known as community health centres (CHCs) with a total staff complement of approximately 3000. Nine community health centres offer a 24-hour trauma and emergency service. During the April 2001 - March 2002 financial year 3.7 million patient visits were made to these centres – over 10,000 patients a day. The total expenditure by the Community Health Services Organisation during this period was R318 million.¹⁴ The growing burden of chronic disease and need for anti-retroviral treatment will continue to increase their claims on the health budget. The proportion of patient visits involving chronic illness is estimated to be 40 - 60% (personal communication, Ms L Solomon, Health Information Officer, MDHS). The cost of the chronic medication bill is known to be on a steep rise (68% in the last year – personal communication, Chief Pharmacist, MDHS). The socio-economic status and disease burdens of the communities served by the 51 CHCs and the impact on service delivery of current limitations in organisational structure and management is outlined in Chapter 2.

Primary care diagnosis and treatment are the responsibility of doctors and clinical nurse practitioners (CNPs). Owing to a shortage of nurses, CNPs often have to fill other nursing and administrative roles. Only 57% of CNPs in the MDHS were practicing as clinical practitioners in 2000.¹⁵ CHC doctors include non-permanent doctors; some doctors are doing their six-month rotation after internship as part of their compulsory community service while others are employed on an ad hoc basis as the need arises – e.g. when a CHC doctor is ill. Non-permanent doctors constitute the majority of the doctors at certain CHCs. The absence of continuity in the staff team adds to the fragmentation of patient care. Doctors work largely independently of each other and the CNPs. In most CHCs doctors and nurse practitioners have their tea and lunch breaks separately. These operational features make it difficult to use opportunities for a team approach to patient care that could include the allied health professionals, social workers and HIV/AIDS voluntary counseling and testing counselors working in CHCs.

Service organisation and management in the MDHS is largely centralised.^{14,16} Information is sent from the CHCs to central management; the extent to which this information assists the development of local services and the process of health care needs to be assessed. There is little opportunity for CHC staff to use their knowledge of primary care and of the local community to develop the service in response to local health needs. The impact on service delivery of current limitations in organisational structure and management is outlined in Chapter 2.

In such an environment the technical and logistical aspects of health care delivery that are more readily visible and easier to define are likely to receive more attention and resources than the less tangible, relational elements needed for effective health care delivery. Yet failure to attend to the

latter may undermine efforts to improve health care delivery and reduce health care disparities, and may increase costs instead. In the future the growing chronic disease burden and anti-retroviral treatment programmes will demand more attention to adherence and the factors influencing adherence to treatment. Continuity of care is known to improve adherence to treatment. The presence or absence of a doctor-patient relationship, a key feature of continuity, has been found to be an important factor in adherence to treatment.¹⁷ There is also evidence to show that, when given the choice, patients prefer continuity of care.¹⁸

Determination of the extent to which a longitudinal relationship exists between doctor and patient in the South African primary care services should be an important part of any drive to reduce inefficiencies, improve health care delivery and increase patient satisfaction. However, given the constraints in the MDHS outlined above, attempting to ensure that every patient has a personal doctor as their usual provider of primary care may not be an achievable goal. A more pragmatic intervention to improve continuity may be needed in this context.

Study purpose

This study was undertaken to measure the extent to which continuity of care is being practiced in the Cape Town MDHS, to consider relevant aspects of the MDHS service delivery context (organizational, socio-economic and disease burden) that may influence the practice of continuity, and to consider a practice team model for improving continuity.

Study objectives

1. Determine the extent of continuity of care practiced in Cape Town Metro District Health Service (MDHS) over a 24-month period.
2. Determine the preferences and views of patients concerning continuity of care.
3. Obtain consensus among senior clinical managers (doctors) regarding their views on ways to improve continuity of care.
4. Propose a practice team model to implement continuity and other elements of family practice in community health centres (CHCs).
5. Determine the views of CHC clinical managers (doctors) with regard to a practice team model to improve continuity of care and primary care delivery generally in CHCs.

CHAPTER 2

LITERATURE REVIEW

A significant body of medical literature on continuity of care reflects the growing interest in the impact of a sustained relationship between doctor and patient on the outcomes of health care.

The global shift in the burden of disease toward chronic illness is focusing attention on the importance of continuity in the delivery of personal health care. The failure to manage chronic illness effectively provides strong arguments in favour of health care reforms that improve continuity of care. Recent policy reports and charters call for the enhancement for continuity in health care delivery.¹⁹ The World Health Organisation Ljubljana Charter on Reforming Health Care urges that reforms reinforce continuity.²⁰

Chronic disease and continuity of care

Health systems have historically evolved around acute and infectious diseases more suited to episodic, reactive models of health care delivery that do not acknowledge a sustained partnership between patient and provider as a core value.^{21,22} There is growing concern about the consequences of relying on such models in the management of chronic illness. Current health systems are not responding well to the needs of patients with chronic illness; these patients are not benefiting from interventions that have proven effectiveness.²³ Swartz and Dick predict that health care expenditure will continue to escalate as long as an episodic care model continues to dominate. They warn of potentially serious consequences if sufficient attention is not given to personal aspects of care.²¹ Poor adherence to chronic disease treatment such as hypertension has

been noted as one such result.^{24,25} Evidence suggests that changes to the structure and organization of health services can improve health outcomes. A systematic review examined the relationship between continuity and the quality of care. 18 studies fulfilled the selection criteria - 12 cross-sectional studies, 5 cohort studies and 1 randomised controlled trial. Continuity was found to be associated with patient satisfaction, decreased hospitalisations and emergency department visits, and better acceptance of preventive services.²⁶ These associations were consistent for continuity in the care of chronic conditions. A study of 11 countries assessed the impact of features of primary care delivery on health indicators. Continuity, when practiced by primary care professionals in a regulated health system, was associated with better health outcomes than in fragmented, unregulated systems - such as in market driven systems where patients initiate visits to medical specialists.³ The findings included an association between continuity and lower health care costs.

The need for continuing care, teamwork and partnership in chronic disease care presents significant challenges to health care delivery as well as to health policy-makers, managers and funders.^{21,24} Successful interventions in this context are complex and require multiple components aimed at a number of objectives that include improving patients' self management and better patient-clinician interactions.²² These objectives demand a partnership between patient, family and provider that cannot be achieved without a continuing relationship. Continuity is necessary to improve adherence to treatment^{27,28} - especially in chronic conditions.^{25,29} The importance of adherence to anti-retroviral treatment to reduce the risk drug resistance makes continuity of care an essential element in the care of HIV/AIDS patients. The gap between acute care practices and the needs of patients with chronic illness have been ignored

by policymakers who tend to emphasise organisational and financial reforms.³⁰ Failure to implement effective models of health care delivery is largely the fault of health care providers and health care systems.²² However, greater patient choice and demand for immediate access to services are contributory factors. This is discussed later in this review.

Continuity in primary health care: concept and definition

As a concept, continuity has strong face validity when viewed as a health partnership or contract between a patient and doctor. Continuity of care has been regarded as a key characteristic of general practice since its recognition as a clinical discipline in the early 1960s.³¹ It is officially considered a core value in general practice in the United Kingdom.³² The Royal College of General Practitioners includes continuity in its definition of a general practitioner as one who provides personal, primary and continuing medical care to individuals and families.³³ McWhinney believes that continuity is the most important element of primary care.¹¹ The different kinds of knowledge held by the patient and the doctor are both important. Continuity is needed for the doctor to learn to use the patient's knowledge and expertise in the partnership and to ensure that treatment makes sense to the patient.²⁵

In primary care continuity is traditionally defined as an ongoing relationship between a single clinician and a patient that is not limited to a specific episode of illness or disease.¹⁹ McWhinney extends the relationship beyond times of ill-health to include periods of health.¹¹ It implies that, in addition to disease detection and management, continuity has a role in the promotion and maintenance of health and the prevention of disease. Hjortdahl adopts a similar view by defining continuity as medical care over time provided by one health care worker regardless of the

presence of specific pathology or not.⁹ Continuity moves away from fragmented patient care toward an integrated care model. In family practice, continuity is more than the duration of care. It implies commitment to the patient and family. A continuing relationship enables observation over time, less need for investigations and the use of counseling in patient care.³⁴

While such a view of continuity is traditionally associated with care by one doctor from the cradle to the grave,³⁵ it is facing many challenges (discussed below). There are also other definitions of continuity. The British Medical Association views continuity as consistency and coordination of care through the use of guidelines and electronic records.³⁶ Haggerty and Stultz point to the need for agreement on a definition to avoid confusion in the methods and findings of research on continuity.^{19,37} A useful definition for research purposes is the percentage of patient visits to the specified doctor in a specified time period.³⁸ Saultz has identified twenty-one techniques to measure continuity and notes that reliable measurement is made difficult by the absence of a clear definition.³⁷ The challenges being faced by the long-held view of continuity described above are leading to new ways of thinking about and defining continuity. These are discussed below.

The elements of continuity

A number of elements to continuity have been identified. The elements themselves are often used to define continuity, adding to the number of different definitions and the difficulty comparing the results of studies.

Longitudinal continuity and personal continuity are regarded as two essential elements of continuity. Both are required for a health care partnership and therapeutic relationship between the doctor and the patient, family and community.^{11, 39} Longitudinal care has been described as an 'ongoing pattern of health care interaction that occurs in the same place, with the same medical record, and with the same professionals'.³⁷ Longitudinal continuity emphasises care over time that, along with good communication skills, teamwork and patient records, enables health professionals to build a comprehensive database of information on the patient and family.⁴⁰ Such information is necessary for accurate diagnosis and treatment in primary care, where personal and contextual factors play a significant role in health and illness.^{11, 34} Longitudinal care implies a consistency in the patient-doctor relationship over time, and use by the patient of the doctor as the usual source of care.¹⁸ While sometimes used interchangeably with personal continuity, longitudinal continuity (care over time) is considered insufficient without the attributes of personal continuity.^{29, 37}

Personal continuity implies a personal relationship between patient and clinician, as well as a sense of contract between the two. It encourages loyalty, responsibility and trust, and improves communication. Personal continuity is thus distinguished from longitudinal care. Longitudinal care together with the medical record ensures the flow of information, whereas personal continuity increases understanding in the doctor-patient relationship. It is characterised by a relationship that ensures that the patient's personal and social context is taken into account in patient care.⁴¹ The terms 'individual patient care' and 'care over time' to denote the two core elements of continuity have also been used.¹⁹

Another schema for describing continuity is in terms of seven dimensions.^{35,37,42}

1. *Chronological* - care of the patient's health over time – over the course of the life cycle or the natural history of the illness;
2. *geographical* - the place of care, be it the surgery, home, hospital - the same doctor being available at all of these;
3. *interdisciplinary* activities involving coordination of care when there may be multiple diseases involving a number of clinical disciplines; this dimension is also known as management continuity and is especially important in managing chronic or complex disease;
4. the *interpersonal* dimension as the doctor-patient relationship described above in personal continuity;
5. an *informational* dimension highlighting the need for adequate record keeping;
6. *accessibility* to care and medical advice; and
7. *stability* of the community and the service.

Longitudinal care covers the first two dimensions. The last two dimensions would be better considered as essential structural features necessary to ensure continuity. The informational dimension is viewed as a core element along with longitudinal and personal care elements.³⁷

Good record keeping (informational continuity) is, however, not sufficient for continuity; records may approximate but cannot adequately reflect the finer relational elements of the doctor-patient interaction.⁴³ Others refer to just 3 types of continuity: personal, informational and management continuity.⁴⁴

In a recent study, experienced general practitioners highlighted three essential aspects to be considered when defining continuity: i) a stable environment, ii) good communication (to ensure a responsible doctor-patient relationship) and iii) a goal to improve the patient's overall health.³⁵ The third aspect is significant because it proposes an outcome – improvement in health. The value given to continuity by patients and doctors validates its importance in health care.^{45,46}

Patients' views and preferences

Patients have a clear preference for seeing the same doctor and getting to know and be known by a doctor that can be consulted for all health problems.^{47,48,49} One study found that 84% of the patients surveyed preferred seeing their regular physician for acute illness. Another study found that continuity was ranked third most important after a doctor who listens and doctor who sorts out problems.⁵⁰ Some patients appear to appreciate choice but are dissatisfied if they cannot see their chosen doctor when they wish. Many patients are willing to forgo choice and endure increased waiting times to see their usual doctor.⁴⁰ These findings suggest that patients may prefer their regular doctor for some problems and a different doctor for others.

Benefits of continuity

Some evidence of the benefits of continuity was given earlier. In a Belgian study, De Maeseneer et al.⁵¹ compared the health service utilisation patterns of 4134 patients registered with the same health insurance plan. Patients were divided into two cohorts – those who attended the same family physician and patients who attended two or more doctors. (In Belgium patients have the choice.) The two cohorts had similar demographic, socioeconomic and health status variables. Seeing the same doctor was again associated with lower total health care costs.

Continuity has been found to reduce emergency admissions.^{52,53} Inappropriate attendance at emergency services is known to be a problem for health service planners and managers. In one study 85% of patient visits to a hospital emergency service were found to be inappropriate.⁵⁴ The number of patients seeking help from emergency services inappropriately was significantly associated with the absence of a regular primary care doctor. Patients who had a regular primary care doctor were three times more likely to use emergency services appropriately.

In a large study involving nearly 26 000 patients and 53 general practices, knowing the doctor well was associated with better quality of care and increased patient enablement than not knowing the doctor.⁵⁵ (Enablement is a measure of patients' ability to cope with their illness and control over their health.) Doctors' knowledge of their patients and sense of responsibility increases with increased longitudinal care.⁵⁶ Continuity ensures coherence in the patient's experience of care even though it involves a series of separate visits over time, often for different problems.¹⁹ It also ensures that the visits are connected by the clinician's knowledge of the patient as well as by the patient record. Continuity reduces time spent on episodic care.¹¹ More effective use is made of information on past events and patients' personal and social context and more productive use is made of available time.⁵⁷ Seeing the same patients enables better feedback on treatment outcomes at follow up visits; observing a condition over time adds to the clinician's knowledge and experience.⁴⁰

A long lasting partnership between a patient and a primary care professional of choice is more likely to result in patient satisfaction and provides opportunities for comprehensive care and the identification of new health problems.^{58,59} In a review of 22 studies examining patient

satisfaction and continuity 19 studies showed a significant association between patient satisfaction and interpersonal continuity.⁶⁰ Continuity is important for patient satisfaction in primary and hospital care.⁵⁹ Some hospitals are now beginning to compensate for fragmented care by assigning one carer to a patient.⁶¹ There is a strong association between patient enablement and satisfaction with a consultation, and visiting the same doctor or knowing the doctor well; there is also a reasonably strong and consistent association between continuity and doctor satisfaction.^{32,62} Experienced researchers in the field are now convinced that there is sufficient evidence to show that continuity is cost effective.⁶³

Consequences of poor continuity

Freeman et al,⁶² noting the findings of a systematic review of literature examining the relationship between the length of general practice consultations and outcomes, conclude that the absence of continuity leads to duplication of history taking and telling, the risk of inappropriate diagnosis, and the potential for the patient to receive conflicting advice. Mechanic⁵⁷ notes that the lack of knowledge from previous consultations (due to the absence of continuity) creates the perception among doctors that there is insufficient time in the consultation, and leads to frustration. In addition, the less well known patients are the more tests are done and the less there is expectant (wait and see) management.⁴⁰

The impact of forced discontinuity – e.g. when patients are shifted from one independent practitioner association to another by managed care organisations – has been studied. Using claims data from an independent practitioner association, one study examined the relationship between the first year of health insurance and Papanicolaou smears, mammograms in women

older than 40 years, patient visits to a doctor, avoidable hospitalisations, and expenditures. The study used a cross-sectional analysis of up to 4 years of claims data from the independent practitioner association involving 335,547 adult patients registered with panels of 687 primary care physicians. After multivariate adjustment for age, sex, case mix and socio-economic status, the first year of insurance was associated with a higher risk of not getting a mammogram, a higher risk of avoidable hospitalisation, a greater likelihood of doctor visits, and higher expenditures - especially for testing. (There was no relationship between compliance with Papanicolaou testing and year of enrolment.) The researchers concluded that there might be adverse clinical and financial implications associated with changing health insurance - i.e. following a breakdown in continuity of care.⁶⁴

Negative effects of continuity

A review study found no evidence of a negative impact of continuity on health outcomes.²⁶ However, Stott notes the risk of failing to detect a problem due to familiarity blindness.¹⁰⁸ It has also been noted that the emphasis on the doctor-patient relationship in personal health care can cause frustration among doctors when constantly faced with intractable problems especially when these are the result of patients' behaviours.⁶⁵ In this context doctors may feel they have to collude with illness behaviours to continue relationships that have little chance of a successful ending. Such frustration could in part be due to a narrow focus on biomedical goals.⁶⁶ In a survey of general practitioners, 80% reported continuity as important or very important but found discrepancies between the ideal and reality.¹² Realistic goals should therefore be set to avoid burnout and the loss of credibility – especially in public sector practice.

Challenges to the practice of continuity

There are a number of factors challenging the practice of continuity outlined above.^{46,63} In some health care systems, there is concern that continuity is being undermined by a competitive market place where patients shift between health plans, and by increasing fragmentation and specialisation in health care. Increased mobility, patients' expectations of easier access to faster services, and having greater choice are also contributory factors. Despite research showing that general practitioners and patients (especially those with chronic or serious conditions) continue to place a high value on personal continuity, there is a growing tendency toward large group practices with bigger shared patient lists and practitioners wanting more flexibility in their hours.^{44,67} Continuity is often ignored by organisational change. In the United Kingdom continuity is facing new obstacles from policy makers who give it a lower priority.^{44,46} In response to these developments, a proposed new definition of general practice has omitted continuity of care as a defining feature but has left an opening for it.^{31,45}

Regarding list size, a cross-sectional survey, involving 25 994 people consulting over a 2-week period in 53 general practices in the United Kingdom, found that list sizes greater than 6000–6500 were associated with marked reductions in personal continuity. The odds ratios (95% confidence interval) for patients seeing their usual doctor for the two largest quintiles of list size (6337–11 036 and >11 037) were 0.24 (0.12–0.46) and 0.19 (0.10–0.37) when compared with the smallest quintiles of practices.⁴⁶

Health service organisation and management

Apart from the personal and relational dimensions of health care, structural and other dimensions of health services also influence continuity - such as the organisation and management of services. Given the challenges to continuity outlined above, advocating that every patient has a personal doctor may not be pragmatic – especially in contexts where managers are struggling to cut costs and improve outcomes. How can the impact of these challenges to continuity be minimised? Are there models of primary care delivery that are able to accommodate what appear to be opposing values - models that ensure continuity acceptable to patients and doctors as well as satisfy the concerns of policy makers and planners? Organising existing human and other resources in a way that improves continuity specifically, and service delivery generally - such as small practice teams, may be a more pragmatic solution.

Practice teams, list size and practice coordination

Recent studies in health services research examine the relationship between practice structure and personal continuity by studying the impact of the size and composition of practices, the size of practice lists and the degree of practice coordination on continuity, patient satisfaction and health care delivery. The results point to benefits for small, coordinated practice teams with personal lists - as a health care delivery model acceptable to patients, able to provide continuity, and to improve health outcomes. The formation of smaller teams of doctors, practice nurses and receptionists within large group practices, creating personal lists from large shared lists,^{44,46, 68} and good practice coordination, are emerging as important to consider in order to align current developments with continuity of care as a core value in primary care. Guthrie³¹ notes: “If GPs

are serious about the importance of personal continuity, then the size of the primary care team needs to be examined.” He suggests separating the administrative functions from the clinical functions of the primary care team to ensure the benefits of continuity without losing the administrative advantages of a large practice. Baker and Streatfield⁶⁸ call for a return to a personal list of registered patients for each practitioner to improve personal continuity.

Others consider continuity with a team to be important rather than with a practitioner. In a cross-sectional study of a health maintenance organisation providing primary care services to 320,000 members and involving 25 Washington State (USA) medical clinics, practice coordination (measured by the extent to which doctors accepted joint responsibility for patient care and clarified their communication structure and team roles) and team tenure of more than 4 years, were significantly associated with higher rates of cancer screening, diabetic management examinations and patient satisfaction. These outcomes were not associated with personal continuity measured over 1 year – probably too short a time period to achieve continuity.⁶⁹

Organisational structure and management

Continuity is affected by how health services are organised and managed. A highly centralised structure may give less importance to needs at the frontline of the organisation. Telleen⁷⁰ has used general systems theory in a critique of centralised organisational structure and management. He notes that conventional organisational structures follow a central command and control model designed to bring information to the central command structure. Central decisions can easily be duplicated, sent to the periphery and enforced, but feedback from the periphery is relatively slow. As organisations become larger and more complex, the number of intermediate steps

increase as does the amount of information that has to be processed. Even with new technology, the central command and control model is stretched to its limits. There is a need to review highly centralised forms of organisational structure and management in response to complex problems. Highly centralised systems hinder their own ability to learn to adapt to challenges (self-maintenance), thus posing a risk to their survival. Capra⁷¹ warns that "...an organisation that thinks only in terms of its own survival (by centralising control) will destroy itself" (Capra (71); p.289).

The above critique can be applied to conventional health care delivery systems. In organisational development, form or structure follows function.^{71,72} Health care literature is beginning to reflect the growing devolution of responsibility and decision-making to more appropriate levels of the health systems for more effective organisational management and functioning. As noted earlier, new patterns of ill-health require changes in health services in order to meet changing needs. This is particularly necessary at the primary care level of the health service where the bulk of illness is diagnosed and managed and where most of the responsibility for health promotion and disease prevention rests. At the level of personal care the devolution of decision-making from doctor to patient is increasing e.g. in changing risk behaviours⁷³ and in the management of chronic disease.⁷⁴ Such appropriate devolution of control to the patient reflects a shift in health care thinking and practice. In addition, the chronic care model, aimed at improving the cost-effectiveness and quality of chronic disease care, emphasises the need for a continuing relationship between patient and provider. Advocates for the model argue for a team approach and comprehensive interventions to ensure that patients with chronic illness have the confidence and skills to manage their condition.⁷⁴

Evidence of devolving responsibility is also emerging in other disciplines. Large companies that move away from a central command and control model and devolve decision-making to multidisciplinary practice teams ('communities of practice'), are more effective in achieving their goals and responding to challenges such as competition from rival companies.⁷⁵

Multidisciplinary frontline teams are considered the best way to store and apply knowledge in response to market needs - rather than central management relying on huge centralised banks of information but with little knowledge of how best to use the information in their response to changing environments.

Family practitioners and researchers have long drawn attention to the limitations of the biomedical model in primary care and continue to argue for a different approach.⁷⁶ Common presenting problems such as addictions, failure to adhere to treatment, and now the lifelong treatment required for HIV/AIDS, cannot be solved by a reductionist, biomedical approach.⁷⁷ Outcomes of such an approach include inappropriate use of technology, estrangement between doctor and patient and patient dissatisfaction.¹¹ There is growing dissatisfaction with modern medicine and the assumptions underlying the biomedical model.^{77,78} These assumptions which underlie the current model of health care delivery are being questioned. Kriel⁷⁸ notes that dissatisfaction stems not only from the inability to cure many diseases but the "inability to manage them in a humane and meaningful way." He argues for a general systems approach to patient care and health service delivery.

The Southern African public health context

Poor continuity has been named as a factor in poor adherence to psychiatric treatment in the South African public sector.⁷⁹ A Nigerian study reports a similar finding.⁸⁰ Patient-held records have been proposed in response to the difficulty obtaining continuity in rural South Africa and Lesotho.^{81,82} In a private practice based study on the acceptability of a 24-hour service (in Bloemfontein and Kimberley) patients indicated a preference for seeing their own doctor and doctors expressed concern at the breakdown of continuity.⁸³ A preference for continuity is implied in a patient survey where 83.6% of the patients requested greater participation in the management of their own problems. Many patients felt that more participation would lead to greater trust and confidence in the doctor and to better adherence to treatment.⁸⁴ Pillay noted that very little is known in the literature about continuity of care in South Africa and sees a role for continuity in caring for a defined practice population, and coordination when patients are referred to other levels of care.⁸⁵

Cape Town primary care context

Helman has noted that indigent patients require more intense follow-up and care and therefore more frequent visits.⁸⁶ Many of the communities served by the community health centres (CHCs) in Cape Town face formidable challenges that include high rates of unemployment, crime and violence, and the HIV/AIDS pandemic.⁸⁷ In a recent study (n=131) to determine the prevalence of risk behaviours in the CHCs (including 2 CHCs in this study), 35% of the participants were unemployed. Only 36.9% of the heads of household were employed, 7.5% of the sample had completed high school education (Grade 12) and 21% had completed Grade 6. While 96.8% of households had electricity and 98.4% had running water on site, 18% lived in informal

dwellings.⁸⁸ These communities are in transition, reflecting old and new disease patterns – e.g. high prevalence rates of chronic diseases of lifestyle as well as infectious diseases such as TB and HIV/AIDS – adding to the primary care workload. The Cape Town Metro District Health Plan⁸⁹ noted that these diseases are major contributors to the burden of disease in the Metropole. Dutton⁹⁰ has argued that low social class families experience a disproportionate burden of illness with significantly higher morbidity and mortality rates. They tend to have more complex and serious problems that are difficult and costly to manage, yet they have fewer health services, less preventive care and greater financial and organisational barriers to accessing health care. These features highlight the inequities and under-servicing that characterise poor communities in Cape Town.⁹¹

Cape Town Metro District Health Services

This review began with reference to the role of continuity in chronic disease care in the international literature. An audit of diabetes care in Cape Town community health centres concluded that the care was poor and failed to provide effective care for diabetic patients.⁹² The authors noted the breakdown in continuity when patients by-pass primary care services and present directly to referral hospitals, but did not comment on continuity within the clinics as a factor in management of diabetes. They suggest that their findings probably reflect chronic care in the public sector throughout South Africa and cite poor patient attendance, poor doctor adherence to treatment protocols and inadequate management of services as reasons for their findings. As noted earlier, the shift in the burden of disease toward chronic conditions shows up some of the weaknesses in health care delivery systems that cannot meet the health care needs of the population.^{21,22,93}

Reports (spanning nearly three decades) of investigations into the structure, management and performance of the CHCs in Cape Town (i.e. the MDHS) reveal the chronic nature of problems in service management and the quality of care. Reports in 1984⁹⁴, 1987⁹⁵, 1988⁹⁶, 1993⁹⁷ and 2000¹⁶ noted problems in management and service orientation, inadequate job descriptions and a lack of vision for service development. These problems are aggravated by insufficient staff, imbalances in the health care skills mix, and heavy workloads. Goosen⁹⁴ and Brand⁹⁵ noted in their reports in 1984 and 1987 respectively, that the origin of the then Cape Town Day Hospitals Organisation was problematical. Established in 1969 to alleviate the overcrowding of hospital outpatient departments, the Day Hospitals Organisation focussed on curative care. The Health Act of 1977 separated curative and preventive services as well as health and social services, and so justified a curative orientation and fragmented care. The reports proposed changes that include more holistic organisation of services. Taylor's observation⁹⁶ in 1988 when referring to the Day Hospital Organisation still applies: ".....(the) service has not kept pace with the increasing demands of a growing population with increasing expectations for (good) health care."

The Kane-Berman report in June 2000¹⁶ on the management of the former Community Health Services Organisation identified staff shortages, heavy workloads and dissatisfied patients among other problems bedeviling service delivery. It found that staff were "de-motivated, demoralised, resentful and mistrustful" and that this led to "excessive absenteeism, burnout and unwillingness to cooperate with new initiatives." The report called for improved utilisation of resources by re-engineering patient flow, clarification of the roles of medical staff (including clinical nurse practitioners), and for management to be more responsive to the workforce.

The Kane-Berman report and comments on the report by Muller⁹⁸ are particularly worth noting as they are the most recent and comprehensive reports. They adopt a general systems approach to identify systemic problems and to propose solutions. Kane-Berman notes that "...it was considered necessary to adopt a systemic, dynamic, transformational approach to problem solving, taking a holistic overview ..." (Kane-Berman (16), p.13). The report calls for changes in organisation and management. It refers to two systems tendencies discussed above - differentiation (decentralisation) and integration (centralisation) - and their role in transforming the then Community Health Services Organisation. The difficulties being experienced in the current transition period are aggravated by the resource constrained environment. Muller⁹⁸ noted that frequent changes have led to a loss of security and structure ("albeit dysfunctional"), that the organisation does not have the resources to cope with staff anxieties, and that there is a need for change management. (Staff have been subjected to many changes in recent years and there is ongoing uncertainty about what the impact of integrating provincial and local authority health authorities will be.) Kane-Berman¹⁶ and Muller⁹⁸ refer to a need for decentralised decision-making and acceptance of responsibility by CHC staff and communities for effective functioning of the service. The Metro District Health Plan 2004 acknowledges "staff attitudes" as a factor contributing to patient dissatisfaction.⁸⁹

Summary

Continuity of care is considered the most important principle of general practice. A growing body of research has drawn attention to patients' and doctors' preference for, and the improved health outcomes associated with, the practice of continuity of care. The absence of continuity results in fragmented and episodic care and is associated with unnecessary investigations,

inaccurate diagnoses, inappropriate treatment and the wastage of resources. The importance of patient choice and the right to continuity are increasingly being recognised. The South African Patients' Rights Charter⁹⁹ states: "No one shall be abandoned by a health care professional worker or a health facility that initially took responsibility for one's health." Although it does not define what it means by continuity, it appears to affirm a sustained relationship with a health service and a health professional as a patient's right.

Large, complex systems such as health service organisations struggle to transform and keep pace with rapidly changing demands. The MDHS and the communities it serves are in transition, reflecting both old and new elements in their composition and activities. Local communities reflect disease and socioeconomic profiles of developed and developing communities. In Cape Town the ongoing tuberculosis and now HIV/AIDS pandemics are significant threats to an already strained service that has the responsibility for diagnosing and managing the bulk of the chronic diseases in its area of operation. It is the nature of transitions that some things get better while others get worse, placing additional strains on all concerned. Appropriate responses and models are required for effective primary care delivery in the Cape Town Metropole. These should consider the recent worldwide shifts in organisational structure, management and patient care, and the findings and recommendations of the reports on the MDHS mentioned above.

CHAPTER 3

METHODS

1. Study design

Table I summarises the quantitative and qualitative methods used in a descriptive study to determine the extent to which continuity of care is practiced in MDHS community health centres and to determine the views of patients and staff on continuity of care.

Table I

	Methods	Objectives
A	Patient record audit	to record evidence of continuity of care.
B	Patient interviews	to determine patients' views and preferences regarding continuity.
C	Nominal group technique	to determine the extent to which senior managers agree on the main factors affecting continuity in CHCs.
D	Focus group	to determine CHC clinical managers' views on a practice model to improve continuity.

2. Record audit and patient interviews

2.1 Population and Sampling

The study population consisted of patients attending community health centers and doctors practicing in these centers in the Cape Town Metropole. Three (3) of the 49 (now 51) community health centres (CHCs) in the MDHS were purposively selected. Selected CHCs had to be staffed by 5 or more doctors to reduce the extent to which continuity occurs by chance, and reflect the workload, demographics and burden of disease seen in communities that are largely indigent, uninsured, and therefore dependant on public services for their health care.¹⁰⁰ One CHC with a predominantly African patient population (Guguletu CHC), one with a predominantly coloured

population (Heideveld CHC) and the third with a mixture of the two groups (Mitchells Plain CHC) were chosen (see note on race).*

After 10 audits and interviews at the Mitchells Plain CHC it was clear that patients had little chance of seeing the same doctor at consecutive visits because doctors rotate through the various clinic services (such as emergency care) on a daily basis as per roster. (The rotation is dependent on the number of doctors available to staff the services.) A fourth CHC (Vanguard CHC) was thus chosen with a profile similar to the Mitchells Plain CHC - i.e. serving a more even distribution of African and Coloured patients.

A sample size of 81 records was required based on an anticipated CHC population proportion receiving continuity of 30% and a precision of 10% for a 95% confidence interval. It was decided that 90 records would be audited to ensure that a minimum of 81 complete audits were available for analysis.

2.2 Patient and record selection

Inclusion criteria were patients who consulted a doctor or clinical nurse practitioner (CPN) on 6 or more occasions in the previous two years. The first 30 consenting patients in each CHC who met the selection criteria were admitted to the study. Paediatric patients were systematically excluded from the sample as children under 12 years of age are seen in a service run separately by the City of Cape Town. The selection process was dependent on the process of patient admission, patient flow and allocation to doctors in the clinic.

*Apartheid race definitions are used because the legacy of apartheid continues to drive inequities in access to health care and other resources. South African Government departments such as the Department of Labour use the following race classification: African, White, Coloured and Indian (Employment Equity Report 2003).

Usual process of patient allocation to doctors at community health centres (CHCs)

Patients are admitted on a first-come-first-served basis. Unbooked (non-appointment) non-emergency patients are admitted via a triage room and those who need to be seen on the day are admitted, while the remainder are given appointments to return at a later date. Patients returning for follow up visits (especially those for chronic care) have a return date and appointment time allocated in hourly batches. At these follow-up visits patient records are drawn in the order of admission and taken to the preparation room in batches from where they are allocated to the doctors. Each doctor is assigned a quota of patients for the day; patients are distributed evenly until the quotas are filled or all the patients have been seen.

Preparation room nurses usually randomly allocate patients to doctors. A patient may be allocated to a doctor he / she has seen at the previous visit or could request that this be done. The request may or may not be granted. While attempts are made to ensure that patients have their consultations in the order in which they arrive, various factors can influence this, such as a delay in finding a patient's record. That patient's progress through the CHC will then be delayed. Patient record covers do not identify doctors seen previously. Doctors could indicate a preference for continuity by recording their names on the patient's appointment card or in the medical notes; by informing the patient or the sorting nurse of their intention; or by a combination of these. Patient selection was spread over different days of the week (mornings) to minimise selection bias. Batches of records were scrutinised as they arrived in the preparation room in the order described. The first record that met the selection criteria was chosen and patient's consent sought. If consent was granted the audit and interview were conducted. When the audit and interview were completed or consent was refused, the next suitable record was selected and so on over 6 –

8 mornings in each CHC until the sample quota for that CHC was filled. Patients who did not meet the inclusion criteria or who refused consent were excluded.

2.3 Record audit

A record audit instrument was designed based on the researcher's knowledge and experience of CHC record-keeping. The instrument was piloted at Heideveld CHC and revised. Three piloted revised audits were included in the study sample. Ninety (90) patients and their records were selected from four CHCs as described above. The records were audited for evidence of continuity of care (Record audit: Appendix 1). Audits and interviews were conducted while patients waited to see the doctors. Records were 'missed' if patients were seen by the doctor before the batches were scrutinized or after the researcher left at the end of the morning.

The number of visits that included a consultation with a doctor / clinical nurse practitioner (CNP) in the previous twenty-four months was determined by counting admission date stamps and doctor / CNP entries for this period. A minimum of six consultations was required. The number of different doctors / CNPs seen at the previous six consecutive visits was determined by scrutinising the entries for doctor / CNP signatures or their handwriting where no signature was recorded. In the absence of a signature and there being difficulty discriminating between entries on the basis of handwriting, the entries were regarded as being from the same doctor / CNP. Patients' appointment cards were scrutinised for a record of doctors' / CNPs' names.

2.4 Patient interviews

Ninety (90) patients were interviewed. Patients' views and experience of continuity were obtained by administering a structured questionnaire (Appendix 2). The questionnaire was based on the need to elicit patients' views and experience of continuity in the CHCs, their preference with regard to continuity and recall of any attempts to ensure continuity on the part of the staff. The questionnaire was piloted and a few minor changes were made. As for the record audit, three piloted revised questionnaires were included in the study sample.

3. Senior doctor-managers interviews

The nominal group technique was used to obtain consensus among MDHS senior managers (chief medical officers) on what they considered to be the main barriers to continuity and how continuity could be improved in the CHCs. This was done with the help of a research assistant acting as a co-facilitator. All five chief medical officers, each with years of experience working in the CHCs, were invited by letter to participate in the study. Four senior managers attended the session; the fifth manager was unavailable.

3.1 Objectives

- (a) To identify what the chief medical officers believe to be the main ways to improve continuity in the CHCs.
- (b) To identify what the chief medical officers considered to be the main barriers to the practice of continuity.

3.2 The Nominal Group Technique Method¹⁰¹

The following describes the process used to conduct the nominal group technique.

Introduction and aim of the exercise

Participants were welcomed and the second facilitator introduced. The aim and objectives of the session as set out above were stated and process of the nominal group technique explained. A one-page handout was given to each participant, briefly outlining the group technique steps to be followed. Time was allowed for any questions of clarification.

Presentation of the questions

The two questions to be addressed were handed out, each on an otherwise blank page for the participants responses to be recorded. The questions were explained to ensure that they were clearly understood.

Question 1: What are some ways to improve the practice of continuity of care in the CHCs?

Question 2: What are the likely barriers to improving continuity of care in the CHCs?

The silent phase

Following the presentation of the two questions, each participant was asked to write down on each sheet his own responses to the questions. Participants were encouraged to record as many responses as possible. This took approximately six minutes per question.

Item generation

Having recorded their responses to the questions, each participant in turn was asked to give one response to question 1. This process was conducted by one facilitator while the other recorded

the responses on a flip chart. It continued in round-robin fashion until all their responses were given. The same procedure was followed for question 2.

Item clarification

The meaning of all the items was clarified to ensure a common understanding by all. Consensus was achieved on which items were overlapping or similar. Participants were keen to discuss the issues raised and it was difficult to confine discussion to clarification of the items.

Prioritisation

During the clarification stage the items for each question were numbered in the order they were recorded to facilitate prioritisation. Each participant was then asked to choose his top 5 items from the list for each question and to rank them on paper without discussion - 1 being the most important and 5 the least important.

Final voting of group

The ranked choices of each member were named and recorded by following the same round-robin format as before. The scribe marked these on the flip charts.

Debriefing on nominal group technique procedure

Participants were thanked for their time and participation, and asked to reflect briefly on the exercise before recording one positive ('like') and one negative ('dislike') experience of the nominal group technique. Two participants felt that they were already aware of the problems and that the process would not help them overcome these. The third felt that it was a helpful process and had no dislikes. The fourth participant had to leave before completing this part of the exercise.

Method to determine consensus on the top five items

A combined top 5 ranking was determined for each question from the ranked lists made in the final voting stage using the following scoring method:

Step 1: Only items selected by more than one medical officer in the final voting step were scored. One point was awarded to an item each time it was selected. (As there were four participants the maximum score in this step is four.)

Step 2: Where items had the same score in step 1, a numerical value was assigned to the rank given by the medical officers in the prioritisation stage (rank 1 = 5; rank 2 = 3; rank 3 = 3; rank 4 = 2; rank 5 = 1) and added to these items. Example: an item selected 4 times and given the rankings 1,3,3,5 would score $4 + 12 = 16$. (Step 2 serves only to distinguish between items with the same score in step 1 and may not over-ride the step 1 ranking.)

4. Focus group with CHC clinical managers

A brief summary of the record audit, patient interview results and a proposed practice team model for improving continuity of care were presented at a monthly CHC clinical managers' meeting. (Clinical managers, formerly known as doctors-in-charge, have oversight of the professional medical care provided by doctors and clinical nurse practitioners in their respective CHCs.) Following the presentation, a request was made for six clinical managers of large CHCs (size not stipulated) to participate in a focus group for one hour at a convenient time during the following week. The main objectives of the focus group were to:

a) determine clinical managers' views (as key informants and stakeholders) regarding the idea of implementing practice teams in their respective CHCs i.e. forming smaller teams of

doctors, nurse practitioners and other staff categories, from a large CHC professional staff complement;

b) determine what clinical managers consider to be important factors when deciding on whether to implement practice teams.

A focus group was chosen as a qualitative method that is able to explore the views and feelings of those who work in and have clinical management responsibility in CHCs (clinical managers) with regard to practice teams - a new idea in public sector primary care delivery - and to reveal the complexity of the context in which practice teams would be implemented, should this be decided.¹⁰²

Eight clinical managers and one programme manager for chronic disease care in the MDHS (a clinical nurse practitioner with over 20 years of experience in the MDHS and CHCs) offered to participate. Two CHC clinical managers were not available at the time that was convenient for the majority of participants.

The help of an experienced qualitative researcher was obtained to assist with the development of the focus group interview guide (Appendix 3) and to facilitate the focus group session. The interview guide was finalised after 4 drafts that involved the focus group facilitator and researcher communicating telephonically, via email and at one face to face meeting.

Communication with participants before the session was via email. Participants received a one-page information sheet (Appendix 4) and a consent form (Appendix 5) on the day before the session.

At time of the session one doctor was unable to attend due to illness and another did not arrive, leaving five focus group participants including the CNP / programme manager. The session was held at the MDHS Head Office where the managers have their regular meetings. The session lasted approximately one hour and was tape-recorded. Refreshments were provided after the session. The taped discussion was transcribed and the main themes identified using the 'cut and paste' method.

5. Ethical considerations

Permission to conduct the study was obtained from the Director of the MDHS, as well as the Facility Managers and, the then, doctors-in-charge of the respective CHCs. Ethical clearance was obtained the Research Ethics Committee of the University of Cape Town. Selected patients were invited to participate and consent was sought using the attached consent form (Appendix 6). Afrikaans and Xhosa versions of the consent forms were available. All the information obtained was kept confidential. Names and other personal details were not included in the questionnaire. Information provided was not entered in participants' medical records. Only the principal researcher accessed the records. Study reports and publications will not identify participants in any way. Consent was obtained from the nominal group technique and focus group participants. No adverse effects on participants' health or health care are anticipated. There are no obvious conflicts of interest.

CHAPTER 4

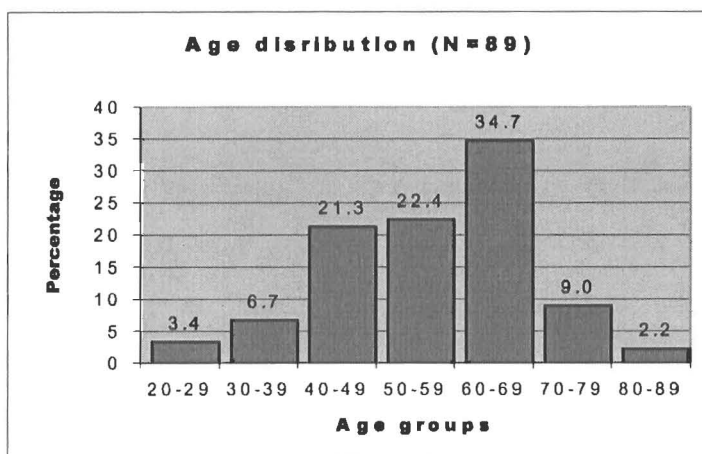
RESULTS

The results of the record audit and patient interviews uncovered a significant gap between the extent to which continuity of care is being practiced in the CHCs studied and the preferences of the patients interviewed. The findings of the nominal group technique session held with MDHS senior managers and the focus group session held with CHC clinical managers show that the managers are willing to consider ways to improve continuity. They also provide important information on the difficulties that will be faced by interventions aimed at improving continuity. CHC clinical managers showed a readiness to consider implementing a practice team model as an intervention in their CHCs.

1. Record audit and patient interview

Patients and their records were selected and invited to participate in the study (as described in the methods section) until 90 patients consented. A total of 97 were selected before the sample size was reached; 7 patients refused consent either to be interviewed or to have their record audited - a response rate of 92.8%. One record audit was discarded because of a researcher error in data collection leaving a study sample of 89. The 10 record audits and patient interviews conducted at the Mitchells Plain CHC (see methods section) were included in the study sample because they reflect the current practice of continuity being audited. 72% of the 89 respondents were female and almost half were over 60 years of age. The age distribution is shown in Figure 1.

Figure 1: Age distribution



1.1 Frequency of attendance in 24 months

42.5 % of the respondents consulted a doctor 11 times or more (range: 6-25). 35% of the patients had consulted other primary care services during the previous 2 years, and of these 86% had consulted private GPs (30.6% of the total sample - 26/85). Continuity with the CHC service itself was therefore interrupted in more than one third of cases.

1.2 Extent of continuity

If continuity is defined as having at least 80% of consultations with the same doctor then continuity was present in less than 9% (8/89) (95% CI: 4.0 – 16.9) of the sample (Table I). If continuity is pegged at, at least 2/3 (66%) of the consultations with the same doctor, then continuity was present in 21.4% (19/89) (95% CI: 13.4 – 31.3) of the sample. Less than 6 percent of the sample saw the same doctor at six consecutive visits (Figure 2). Ninety two percent (82/89) (95% CI: 84.6– 96.8) of the respondents preferred seeing the same doctor at each consultation (Figure 3), yet only 15.7% (14/89) (95% CI: 8.9 – 24.9) saw the same doctor at each consecutive visit (Figure 2). A total of 40% of the respondents reported that a doctor had

expressed the need to see him or her at the following visit. Only 50% (19) of this group knew the doctor's name. Doctors' names were written on 13.5% of the respondents' appointment cards.

Table I: Extent of continuity

% Continuity	Number of patients (%)
16.7	14 (15.7)
33.3	44 (49.4)
50.0	12 (13.5)
66.7	11 (12.4)
83.3	3 (3.4)
100.0	5 (5.6)
Total	89 (100.00)

Figure 2: Percentage of patients seeing the same doctor 1 - 6 times over 6 visits

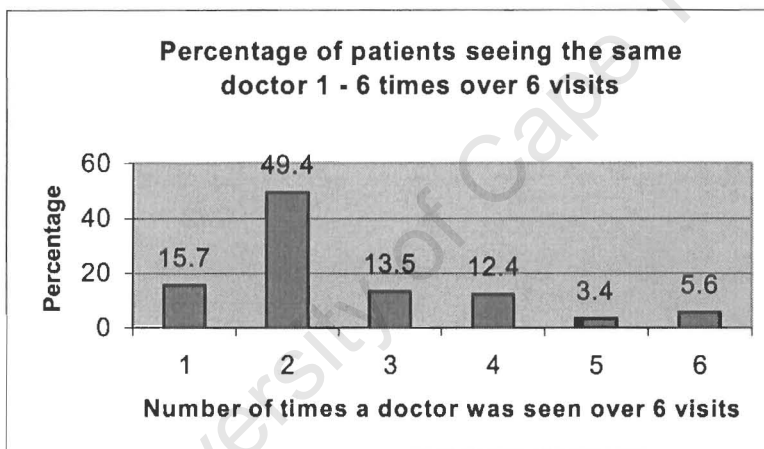
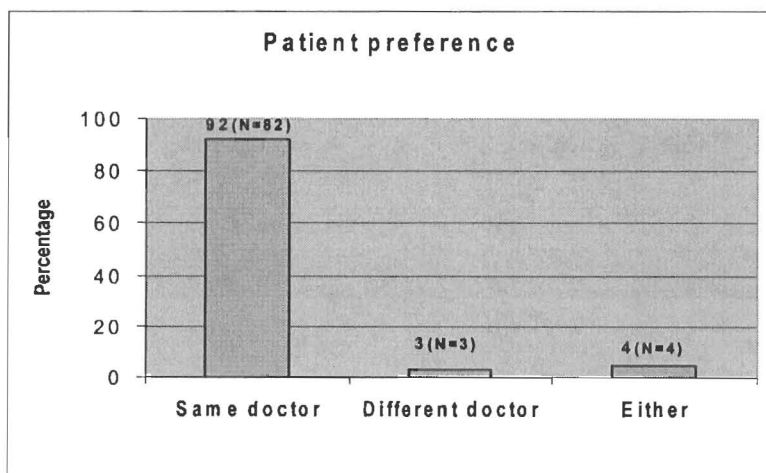


Figure 3: Patient preferences



1.3 Patients' reasons for preferring continuity

Questions 3.1 and 3.2 of the questionnaire (Appendix 2) required respondents to state their preference regarding continuity and to give reasons for their preference. Patient responses (reasons) were recorded on the questionnaire at the interview and later transcribed into a single document. All the responses to question 3.2 were scrutinised to identify common themes using the cut and paste method. Six main themes were identified. Responses relating to the quality of care were combined with those referring to effective treatment and care, leaving five main themes. They follow in rank order starting with the most common and ending with the least common theme. The number of responses for each theme is given along with selected responses.

The importance of the doctor knowing or understanding them or their problem (48).

"(With continuity) the doctor gets to know you - otherwise you remain strangers to each other."

"You don't have to tell your story over and over again."

"The doctor will understand me better and will pick up changes more easily e.g. if I do not take my tablets and my BP is then high. The doctor will show more interest because the doctor will get to know me."

Frustration and other problems (21)

Patients expressed frustration and referred to problems they experienced in the absence of continuity. These include having to explain presenting problems repeatedly to different doctors.

"You have to repeat everything when you see different doctors; the doctor interrogates you all over again."

"(If you see different doctors) you have to repeat things over and over again and they change your tablets. One doctor makes it easier to talk."

"One doctor will get to know my faults; I don't have to tell her every time; you get fond of the doctor and how they work with you."

The importance of the doctor-patient relationship (19)

"Developing a relationship will help to discuss other matters - not just my chronic problem."

"(The same doctor) is easier to approach with questions."

"Doctor and patient will build a relationship, a better understanding. The doctors will learn from follow-up checks."

Problems arise when different doctors give different information and treatment (10)

"Different doctors, different stories. (If I have one doctor) then I will know where to go; we will understand each other."

"Different doctors change your tablets. One doctor will learn to understand you."

"The same doctor knows what's going on with you. You're not happy with a different doctor every time. Different doctor, different story and they keep asking the same questions each time instead of reading the file. It's frustrating. The same doctor will get to know your sickness; I get to know the doctor, he gets to know me."

The benefits of continuity: effective and quality treatment / care (9)

"The same doctor will know exactly what my problem is, for example my blood pressure. He can see whether there is progress and if my medication is working or not."

"The doctor will pick up changes more easily."

"The doctor will know what to do."

"The doctor would examine me. What we want is a doctor who will examine you."

2. Results of the nominal group technique with the senior doctors / managers

During the nominal group technique process managers showed an understanding of the importance of continuity and were very willing to offer responses to the two questions posed. Calculation of the scores for the two questions as described in the methods section is given in tables 1 and 2.

Fourteen (13) items were generated in response to the first question: 'What are some ways to improve the practice of continuity of care in the CHCs?' These are (figures indicate the number

of times an item was selected in prioritisation stage and the ranking assigned in each case; some items were not selected at all):

1. Improved relationships with the Universities (access to libraries, evidence-based care information and assistance with ongoing staff education were mentioned). 2
2. Developing an effective appointment system in CHCs. 1,3,3,5
3. Planning work schedules (roster duties and leave) that favour continuity. 1,2,2,4
4. Developing a vision for continuity that becomes policy and is translated protocols that allow the impact to be measured. 1
5. Raising community awareness on the role of continuity. 4
6. Conducting case management meetings, clinical audits and peer review. 5,5
7. Improved record keeping. 4
8. Better administrative support systems (e.g. more clerks; better records, filing and patient flow.) 2,5
9. Improved links between the CHC and the local community. 4
10. Re-designed patient records with a view to facilitating continuity.
11. Ensuring sufficient staff and improving staff recruitment, retention and human resource management; keep the workforce motivated e.g. by giving feedback to staff 1,3
12. Implement disease registers linked to the primary provider
13. Improved clinic design to improve patient flow (and user friendliness?). 3

The top 5 ranked responses to question 1 and the total score are:

1. Planning work schedules with continuity in mind (19).
2. Developing an effective appointment system (16).

3. Ensuring sufficient staff, better recruitment, retention and human resource management (10).
4. Better administrative support systems (7).
5. Conducting case management meetings, clinical audits and peer review (4).

Eighteen (18) items were generated in response to question 2: 'What are the likely barriers to improving the practice of continuity of care in the CHCs?'

1. Poor community understanding of the need for continuity resulting in a poor demand for it. 2
2. The current practice of rotating doctors within and between CHCs. 2, 1
3. Patient and community attitudes ('Some patients do not want to see their original doctor')
4. A high staff turnover. 1, 4
5. Increased patient load leading to increased workload. 2, 2, 3
6. The triage process (fragments care)
7. The absence of staffing norms - i.e. no minimum doctor to patient ratio 3, 4, 1
8. Increased absenteeism among staff. 3
9. Poor administrative support and inadequate appointment systems. 3, 5
10. A lack of funds for quality of care measures such as clinical audit. 1
11. Exploitation of the doctor-relationship. (Patients making unnecessary visits and demands.) 4
12. Current organisational culture / lack of awareness (not well disposed to continuity of care)
13. The absence of (patient care) policies (protocols) and practice standards hinder continuity. 1
14. A lack of regularity in work scheduling (e.g. frequent changes are made to duty rosters and the way they are drawn up) 5
15. A lack of adequate clinical management skills (e.g. among junior doctors). 5, 5
16. The frequent use of locum doctors / scarcity of permanent doctors. 4

17. The service organisation's lack of understanding of the benefits of continuity and the costs of poor continuity. 2
18. Inadequate record keeping and poor legibility (inadequate resources (including stationery) and administrative support mentioned as factors)

The top 5 responses to question 2 are:

1. Increasing patient load / increasing workload (14)
2. The absence of staffing norms (13)
3. The current practice of rotating doctors within and between CHCs (11)
4. The high staff turnover (9)
5. Poor administrative support and appointment booking systems (6)

3. Results of the focus group with clinical managers

The following statement made early in the focus group session by one of the participants captures the essence of the participants' responses:

"I think that in principle it's an excellent idea, but I do think that it is going to be difficult to implement. And if we look at a time span for continuity of care, we're looking at a very high turnover rate of staff,"

The statement refers to 2 key themes that emerged during the discussion: practice teams are "a good idea" and, implementation of practice teams will face many challenges. It also reflects the frustration expressed throughout the focus group session at a number of difficulties currently

faced by the clinical managers – and that will challenge the implementation of practice teams in CHCs.

These concerns notwithstanding, there appeared to be agreement among participants' that the practice team model is 'a good idea' to improve continuity of care. High turnover staff in many CHCs was one of a number of factors given as potential barriers to implementation. Frequent reference was made by all the participants to the chronic care clubs (e.g. for diabetic and hypertensive patients, longstanding features of chronic disease care in CHCs) as an example of a team-like approach to patient care. There were, however, reservations about whether the chronic care clubs reflect a team approach and concern that they may fragment care and pose a barrier to practice teams aimed at providing comprehensive care.

The more recent implementation of an appointment system in CHCs was used as an example to illustrate the difficulties encountered and the lessons learned when new interventions are implemented. Participants discussed how they would go about getting staff members' cooperation in implementing the practice team model. They generated their own ideas on how they would proceed with implementation and offered their views on practice team composition, operation and leadership. An analysis of the transcript highlighted the following themes:

3.1 Practice teams are worth considering as an intervention – “a good idea”

Analysis of the data reveals some of the reasons why participants seem willing to consider practice teams. Continuity with one practitioner and the doctor–patient relationship were

mentioned as important in patient care. Spontaneous comparisons were made with the chronic care clubs, revealing further reasons:

“So certainly the (practice team) is a far healthier approach to the (chronic disease) club situation.”

“Personally I’ve never really thought that the club in itself is such a good idea. It’s working on a similar type of concept which is better than having nothing at all, but I think that this (practice team) is a better approach, really. The convenient aspect of ‘diabetics today’ (diabetes club) is that everyone’s got their mind set to be getting diabetics today, which isn’t a really healthy mindset.”

Other responses suggested that participants feel that practice teams would reduce the negative impact on continuity of high staff turnover by providing an opportunity to bond with team (as a more constant entity) instead of a single doctor or nurse practitioner (CNP). An example was given where, after a CNP left a chronic care team, the team provided continuity for the patients concerned. It was mentioned that practice teams will reduce the workload and encourage team spirit and decision-making at clinic level and that staff would experience this as empowering. Patients and staff would eventually see the value of practice teams once they are in place.

3.2 Barriers to practice team implementation and functioning

The high staff turnover in CHCs appears to be a frequent frustration for managers as it impacts on many aspects of service delivery and the quality of care. Concern was expressed at the

potential wastage of resources spent on staff preparation and team development and the negative impact on continuity if team members leave or are assigned to duties elsewhere.

“It’s definitely going to be a negative impact You would have invested in that particular team, with capacitating them, the acquired skills and all of that, and then they leave, then you’ve got to get new ones in again. The patient also (then) needs to understand a new person.....”

Other factors mentioned include an unhelpful “staff mindset”; staff are not accustomed to a team approach to patient care. It may also be difficult to obtain the full cooperation of patients. It was noted that some patients pressurise clerks into deviating from the agreed protocol for making appointments. Experience with implementing the appointment system suggests that it may be difficult to get other staff to support the implementation of practice teams; some staff are reluctant to change. There was concern that nurses are not empowered to make decisions and that this would hamper their function in the practice team.

“So for the system (to) work the mindset of the staff is the biggest problem for me, to get them to buy into anything new I find very, very difficult. You have to get the staff to accept changes. That would be my biggest worry. It won’t be getting people to be on the team, they will come on, but then to get the rest of the staff to work together and support that team (will be difficult).”

“(Staff members are) tired of being told ‘you’re not doing a good job’ – they get depressed even further.” (They are likely to respond negatively): ‘This is going to be far too difficult for us’ (They) will need to have a very clear idea of what one has in mind.”

The difficulty obtaining the cooperation of staff is related to their experience that change adds to their already heavy workloads and their frustration at the lack of basic equipment. Improving the work environment and providing essential equipment will motivate staff.

“If I can have every doctor having a diagnostic set, I’ll have a happier doctor.” (The other participants indicate their agreement with this response)

3.3 Implementation

Implementation of practice teams was referred to as a process that cannot be achieved overnight. Participants suggested piloting the practice team in selected CHCs and offered ideas on how to proceed. A number of factors need attention if practice teams are to have a chance of success.

These include:

- ensuring some staff and patient cooperation (*“then it will spread to others”*);
- using chronic care clubs as a precursor to practice teams;

“The diabetics come in on one day, most of the diabetics, and then it’s called the diabetic club. So already that kind of structure is there... I think one can work from there, I think one needs to work with what one’s got and roll out from there.”

- integrating the implementation of practice teams with other strategies aimed at improving the quality of care such as those contained in the Western Care 2010 Provincial Health Plan; the objectives of the practice team model were considered by participants to be in line with those of the 2010 Plan, and
- staff orientation, education and training.

A number of responses noted the need for clarity regarding the objectives of practice teams, plans to implement practice teams and the role of each member in the team. Clarity is also needed regarding the relationship of practice teams to existing chronic care clubs and how they will be integrated as there is potential for conflict between the two. There was uncertainty as to whether continuity is a feature of the chronic disease clubs:

“But I don’t know if they were seeing the same patients, you know, because it’s... depending on whether one had worked the night before and one was sick, or whatever, then they would see different patients as well.”

Clubs may be fragmenting care:

“There is fragmentation in that, because diabetics go to the diabetic club and hypertensives going to the hypertensive (club).”

The benefits of the clubs are that they are convenient for patient education, patient support and the dispensing of chronic disease drugs. These benefits notwithstanding, participants expressed

their reservations concerning the chronic disease clubs (in addition to the reservations quoted above):

“So it does help in all those ways, but I think (name of participant) is right, the club is OK, but adding this point now, this sort of (practice team) thinking, would probably give us a much better quality of care.”

“Obviously this (practice team) would be a more holistic approach that we’re suggesting now; the club is a more fragmented situation, where you just focus on the one aspect in a sense you tend to lose sight of the overall, so easily. So certainly the (practice team) is a far healthier approach than the club situation.”

It was also noted that the rotation of staff must be stopped:

“The nursing staff are very unhappy having to rotate through the different (clinic) stations. That creates a problem among the staff so we don’t get that team spirit because they are unhappy where they are.”

Practice teams were considered to be more suited to the bigger CHCs as there may be too few staff to make a team in small CHCs.

3.4 Leadership, composition and functioning of practice teams

Practice teams should meet to discuss patient care: *“Like a little ward round”* It was suggested that clinical managers should take responsibility for the practice teams and that teams

have at least 3 or 4 staff members to minimise the negative impact of staff turnover and ensure at least some continuity. Regarding the composition and size of practice teams, it was noted that these will differ depending on size of the CHC; the practice team should be an “*inclusive team*” and be “*widened*” to include all categories of staff.

Implementation should begin in selected CHCs, although it was felt that the CHCs that are unlikely to be selected for piloting (because of staff reluctance to change and/or fear of change) will probably be those where practice teams are needed most. The involvement of CHC clinical and facility managers and motivated staff are seen as essential to successful implementation. Planning an approach to implementation is best done by involving the staff in determining how this could be done; staff participation in key decision-making will help to “*.....get round change fatigue...*” and encourage initiative:

“There are ways to approach this. (Saying to staff): ‘Things are not working here.’ and engaging them in a (discussion) where they have opportunity to express themselves and we brainstorm: ‘how do you think we can incorporate this (practice team) to help you?’”

The others participants indicated agreement; one responded:

“That’s good. You actually lead them ... give them some ideas and then they come up with what they want. They’re tired of changes. It just doesn’t work. It works if they understand.”

Other ideas that were offered regarding implementation include:

- identifying willing staff;
- starting small and allowing small successes to influence others;
- identifying a “*driver*”; clinical managers view themselves as key role players; the facility and clinical managers should drive implementation initially:

“I’m thinking initially you’d probably have to get the facility manager and the doctor to drive it, but once it’s in place it wouldn’t be necessary to drive, it could drive itself.”

(Other agree)

- “*driving*” implementation from within will avoid more bad experiences of change being driven from outside;
- regular, “*good quality*” practice team meetings will help to manage “*unwilling workers*” and will encourage initiative, and
- regarding negotiating team member roles, “*....each team should decide for itself*”
(other participants indicate their agreement) based on their own pool of expertise.

The focus group discussion thus reveal a real interest in practice teams among participants. They also showed a willingness to consider implementing practice teams and to generate ideas on how to overcome barriers to implementation. The following statement reflected the tone near the end of the session: “*I think you will find people will be quite keen.*” The participant then quoted a colleague to whom she had mentioned practice teams: “*‘Ooh! I’d like to be in a team like that.’*”

CHAPTER 5

DISCUSSION

- 1. Main findings**
- 2. Discussion of results**
- 3. Recommendations**
- 4. Practice Team Model**
- 5. Conclusion**

1. MAIN FINDINGS

The extent of continuity in the CHCs studied was lower than expected. Based on the definition of continuity used for the record audit, continuity was present in less than 9% of cases. 92% of the patients interviewed preferred to see the same doctor at each visit. Many patients expressed frustration at the service and the impact that poor continuity had on their care. Patients' views seem to concur to a large extent with the medical views of continuity and its importance.

With regard to senior doctor managers' views, the nominal group technique achieved consensus among them on what they believe is needed to improve continuity and the barriers that will be faced in attempts to do so. The top ranked items were largely related to community health centre staffing, performance, and management and concur with reports of investigations into various aspects of the MDHS and the CHCs.

The focus group with CHC clinical managers showed support for testing a practice team model as an intervention to improve continuity while noting a number of obstacles such an intervention would face. They expanded on the content of the items listed by the senior managers in the nominal group technique session and offered suggestions as to how these might be overcome. Clinical managers are willing to help pilot the practice team intervention in selected CHCs and to take a lead in doing so.

2. DISCUSSION of RESULTS

Record audit and patient interviews

De Maeseneer and De Prins et al in their study defined continuity as being present only if all consultations were with the one doctor.⁵¹ Parkerton⁶⁹ notes, however, that it may be difficult for patients to see their usual doctor for 75% of visits. The operational definition of continuity used in this study (seeing the same doctor for at least 80% of the consultations) was considered reasonable given that continuity has not been promoted as an important feature of the primary care process in the public health sector.⁸⁵ It may be argued that given this and other factors such as resource constraints and the high turnover of staff, it may have been equally reasonable to define continuity in this study as seeing the same doctor for at least two thirds (66%) of consecutive visits. In this case continuity was present for 21.4% of patients. Continuity could also have been defined as seeing no more than two different doctors over the six consecutive visits. The results (Chapter 4, Fig.3) show that only 9% of the patients saw no more than two different doctors. By all accounts continuity is poor in the CHCs studied. In addition, patients reported that few attempts were made by staff to encourage continuity. Doctors' names were

written on only 13.5% of interviewed patients' appointment cards and few patients knew a doctor's name. Without knowing a doctor's name, it is difficult for a patient to request to see that particular doctor. This contrasts with a clear patient preference (92%) for seeing the same doctor at each consultation.

46% of the patients in the sample were 60 years of age or older. A growing body of health care literature regards continuity as especially important in the management of chronic disease (Chapter 2). Chronic disease patients are more likely to experience the negative outcomes associated with poor continuity. Another significant finding is the high proportion of frequent visits to the CHCs. Once control of chronic disease is established, consultations with a doctor are only needed every 3 - 4 months. Well-controlled diabetics, for example, should need 6-8 consultations over 2 years.⁹² Nearly half the patients interviewed were seen by a doctor 11 times or more in the 24 month period – almost double the expected rate for a well-controlled chronic disease. This may in part be due to the poor continuity. More frequent visits may also be due to aspects of the structure and management of the service as well as the low socio-economic status and the high level of unemployment in the surrounding communities.

Continuity with the CHC was interrupted in more than one third of cases, implying separate patient records elsewhere that are not linked in any way. Access to records at another CHC or another primary care service is problematic; records are not computerised and have to be requested and transported. By the time the necessary information is obtained investigations and treatment may well have been duplicated. It is not known how many patients attending CHCs have records elsewhere but this study suggests one third.

Poor continuity is a function of poor access to services after hours. Patients seeking primary care after 4pm on weekdays, on weekends and public holidays either attend private general practices, or a CHC with a 24-hour emergency service if their regular CHC does not provide such a service. The majority (86%) of those who used other primary care services had consulted private general practitioners in the 2-year period reviewed. Being uninsured, consulting private practitioners will have been costly for these patients. Some patients (number not determined) also attended other CHCs within regular hours. Poor clinic continuity reflects the fragmentation of the service and is a cause for concern given the potential for wastage through duplication and the increased risks of poly-pharmacy and adverse drug interactions. There is also increased risk of confusion when information and diagnoses may differ from one clinic and doctor to another. One CHC (Heideveld) has introduced a 'smart-card' for patients with chronic disease – a form of patient-held record that includes the diagnosis and list of chronic medication. The extent to which doctors and patients are using the card and the impact on care have not yet been studied.

Patient dissatisfaction and frustration are known results of poor continuity (Chapter 2). Yet most patients did not ask to see the same doctor at a follow-up visit. Some had done so but were met with responses that discouraged them from asking a second time. Patients' responses show an understanding of the relationship between continuity, the doctor-patient relationship and the quality of care and suggest that they are likely to support interventions aimed at improving continuity of care.

While these findings cannot be automatically applied to other CHCs in the MDHS, the other components of the study involving senior and clinical managers gave no indication that these are

isolated results. They also concur with patient preferences found in other South African studies^{83,84} referred to in Chapter 2 and suggest that patients are likely to support interventions aimed at improving continuity.

Senior managers' views

The chief medical officers' willingness to participate in the nominal group technique session and their responses showed that they attach importance to continuity and the quality of care. Their top ranked items suggest that the findings of the Kane-Berman Report in June 2000¹⁶ and earlier reports remain operative after many years, continuing to negatively impact the MDHS and its ability to deliver effective health services. It is not surprising that they identified similar factors when considering the barriers to improving continuity as these can also be seen as causes of poor continuity. It may also be that the immediate barriers are obvious while the underlying causes such as organisational structure and management (identified in the reports discussed in Chapter 2) are less apparent or more complex to remedy. It may have been more helpful to generate ideas on possible solutions.

Views of CHC clinical managers on a proposed intervention to improve continuity

The results are fully described in Chapter 4 and speak for themselves. While there was no attempt by the facilitator to encourage comparison between practice teams and the chronic disease clubs, participants frequently referred to the clubs. Clubs for patients with common chronic diseases (hypertension, diabetes, asthma and epilepsy) are a longstanding feature in the CHCs. Although they are a convenient way to deliver chronic disease care, they fragment care and, in their current form, will undermine the objectives of practice teams. No opposition was

offered to those who expressed their reservations about the value of the clubs. Team-based chronic care clubs are possible within a practice team framework but shifting a long-established mindset in the CHCs may be difficult. The suggestion that the idea of clubs be used as springboard for implementing practice teams will need further examination.

Clinical managers' experience with the appointment system suggests that it may be difficult to get other staff to support the implementation of practice teams. References to staff reluctance to change, lack of empowerment of nurses to make decisions and the impact of negative feedback on staff performance concur with the findings of the Kane-Berman report.¹⁶ The discussion also revealed support for decentralised decision-making and some autonomy at CHC level proposed in the Report. It was suggested that practice teams would encourage decentralised decision-making and empower staff by allowing them to openly and critically reflect on service delivery and how it can be improved and take initiative in deciding on their roles in the team.

The focus group discussion aimed to draw out aspects of the 'lived experience'¹⁰² of clinical managers in their everyday work and give meaning to their work experiences and how these influenced their views on practice teams. The participants provided detailed insights, based on their experience, of factors likely to hinder efforts to improve continuity. These factors were similar to the items listed by the senior managers in the nominal group technique as obstacles to continuity. Despite the additional workload, clinical managers appeared willing to consider taking a lead in implementing practice teams in their CHCs. CHC clinical managers are frontline managers and key stakeholders in ensuring quality and cost-effective primary care delivery.

They have a significant role in identifying, implementing and monitoring interventions aimed at improving the quality of primary care delivery at CHCs.

The findings of this study suggest that all seven dimensions of continuity outlined in the schema in Chapter 2 are negatively affected by the factors identified in the record audit and the interviews with patients and managers. The absence of a mechanism to ensure that patients have a usual doctor that they see at each visit and the high staff turnover that further reduces a patient's chance of seeing the same doctor, undermine the chronological, interpersonal and informational elements of continuity. In addition to adversely affecting these elements, poor continuity with the CHC, aspects of CHC service delivery and the fragmentation of primary care services in the Cape Town Metropole make it difficult to attend to the geographical, accessibility and stability elements.

Quality of data, methods and study limitations

Record audits are widely used to evaluate the quality of care even though the quality of recorded data is often uncertain. In order to determine the number of different doctors seen at six consecutive visits this study relied on data recorded routinely at each patient visit – a date and a doctor's entry in the patient's record. When it was not possible to decide whether two or more entries were from the same or different doctors, they were counted as entries made by the same doctor. Conducting the audit on different days of the week will have reduced any systematic bias due to differences in patient care or patient profile on different days of the week. (Certain days of the week are given to the care of specific chronic diseases.) The study sample was small and was not stratified by age or type of presenting complaint. A sample size of 81 records was calculated

for an anticipated CHC population proportion receiving continuity of 30%, and a precision of 10% at the 95% significance level. 89 audited records were entered into the study.

The selection criteria also resulted in some sampling bias toward patients with chronic illness - older patients who attend more frequently. The age distribution confirmed this and is similar to that found in an audit of diabetes care in CHCs in the MDHS.⁹²

The majority of patients who were selected were willing to be interviewed. Only 7 patients refused - either because they were unwilling to be interviewed or have their records audited, or because they were concerned about losing their turn to see the doctor or at the dispensary. The interviews were conducted in the clinic where patients are less likely to comment negatively on the service. A reluctance to comment critically may also have been a reason for refusing to participate. Conducting the interviews in the clinic will also have excluded patients who no longer choose to use the service due to dissatisfaction. It is therefore likely that negative comments regarding continuity are under-represented in the study sample.

The nominal group technique is a consensus method used to enable decision-making in a context where the necessary information is inadequate or absent. Consensus methods aim to determine the extent to which expert or lay participants agree about a given issue (consensus measurement) and to resolve disagreement (consensus development), using qualitative means to derive quantitative estimates.¹⁰³ In this instance the insights of senior managers, with expert knowledge of the context, were harnessed to determine the main factors negatively influencing continuity of care in the MDHS and how these may be overcome. The nominal group technique enables the

generation of ideas in a safe environment and encourages ownership among key stakeholder participants.¹⁰⁴ Giving responsibility to the participants for item generation and clarification reduces the influence of the researcher. The small size of the group will have reduced the number of items generated. However, each participant was encouraged to generate as many responses as possible in the item generation round. As the topic related to the everyday work of the chief medical officers it is unlikely that any significant items were omitted.

Focus groups are increasingly being used in primary care / family practice research to obtain insight into the perceptions, views and behaviours of patients and medical staff on a relevant topic. Such information is important when considering what may help or hinder the uptake or implementation of services and is difficult to obtain from pre-determined questionnaires. In this instance it is important to determine the views and feelings of CHC clinical managers as key stakeholders.

Although the clinical manager participants are experienced practitioners with years of service in the MDHS, and having worked in more than one CHC, the strength of the focus group findings is limited as only one focus group was conducted. This is insufficient to confidently draw conclusions and to appropriate the findings to other CHC clinical managers. The validity of the data could be tested by conducting focus groups with the remaining managers or administering a questionnaire based on the information obtained thus far. It is also important to determine the views of clinical nurse practitioners as they will be important stakeholders in the formation and composition of practice teams. The focus group findings are nevertheless supported by those obtained from the other methods of inquiry used; e.g. the nominal group technique with senior

managers also noted the high rate of staff turnover and poor continuity. The record audit and patient interviews likewise highlighted the lack of continuity and dissatisfaction. (Staff dissatisfaction and turnover also emerged in the review of reports on other investigations into aspects of the now MDHS.)

Although the focus group participants were self-selected, they are an important subgroup to involve at the outset. It is helpful to obtain the views of those who are favourably disposed to an idea as they are more likely to offer useful information for implementation and to become advocates for change. The focus group method is based on the recognition that participants have valuable knowledge and experience to offer. It therefore has the potential to encourage involvement of participants beyond the focus group itself. The clinical managers' detailed ideas on how to proceed with implementation may support this hypothesis but it will need to be tested.

This study shows the benefits of applying a multi-method approach when seeking a deeper understanding of aspects of patient care and service delivery. The qualitative record audit assessed the current practice of continuity in the CHCs while qualitative patient interviews, the nominal group technique and the focus group helped to identify the main concerns and experiences of important stakeholders, the meaning they attach to these, and how these may influence implementation of a proposed intervention aimed at improving continuity and the quality of service delivery.

Main implications and integration of study results

The main implications of the study findings follow from the negative impact of poor continuity on the effectiveness and quality of primary care delivery as noted in the literature review

(Chapter 2). Patient dissatisfaction in response to poor continuity is likely to be accompanied by other negative outcomes such as wastage of resources and fragmentation of care leading to the duplication of services as well as unnecessary servicing. It is also likely that if continuity is not improved the goals of the Cape Town Metro District Health Plan and the Western Cape Provincial Health Plan^{89,105} as well as the values of the South African Patients' Charter¹³ which includes cost-effectiveness, quality care, patient satisfaction and continuity, will not be realised.

In considering the relevance of these findings it is important to note the growing concern world-wide at the failure of health services to deliver cost-effective care in the face of changing disease patterns (noted in Chapter 2). Epping-Jordan²⁴ notes that 'health status and quality of life will not be improved solely by medication and technical advances.' Diseases of lifestyle require multifaceted, complex interventions that include the knowledge and skills necessary for risk behaviour change and to build a partnership between patient and provider. These are difficult to establish in services orientated to diseases where continuity is considered to be less important.

New models to improve health care delivery are needed – models that can accommodate changing health needs and human and other resource constraints. In this instance they have to withstand the challenges of changing emphases in health policy, doctor and patient preferences, as well as local factors such as high staff turnover, low staff morale and high absenteeism rates.¹⁶ In addition, large and complex organisations have to devolve decision-making and knowledge bases to lower level, semi-autonomous structures and improve central coordination in order to remain functional and effective.⁷⁵ A practice team model (Chapter 2) that takes these factors into account is proposed and discussed along with other recommendations aimed at improving

continuity and ultimately the quality and cost-effectiveness of primary care in the Cape Town Metro District Health Service.

3. RECOMMENDATIONS

A number of relatively easily achievable measures could be implemented to improve continuity in the short term. These include informing staff of the importance of continuity and ensuring:

- that doctors and nurse practitioners wear name tags, their names are clearly marked on the doors to their consulting rooms and their names recorded on patients' appointment cards;
- that appointment systems facilitate the allocation of patients to the same practitioner;
- that staff are not moved from room to room without considering the impact on continuity;
- that duty rosters favour the practice of continuity;
- that staff – e.g. preparation-room nurses - are encouraged (with incentives?) to facilitate continuity of care. (Some patients interviewed expressed frustration at the unhelpfulness of staff when they requested to see a doctor they had seen before.)

In addition there are measures that will require more effort and commitment to implement but are important to consider in the longer term:

- consider implementing practice registers or patient registers linked to specific doctors;
- consider extended opening times to reduce the need for patients to seek help at other primary care services after hours;
- consider attaching patients to a personal nurse practitioner, in view of the high turnover of doctors.

It is important to note however that, while these may be obvious and achievable interventions, they do not have the advantages of a team-based approach and do not address the need for fundamental change in organisational structure and management as intimated by Kane-Berman and Muller.^{16,98}

4. A PRACTICE TEAM MODEL FOR PRIMARY CARE

The findings of this study and reports on the Cape Town Community Health Services Organisation (now the Metro District Health Services) show that there are a number of obstacles to achieving continuity. An important question is whether continuity, a core value of general practice worldwide, is a reasonable expectation and goal for Cape Town public sector primary care services. Assuming that current resource constraints will continue for some time, are there ways to improve continuity in this environment and simultaneously address constraints in the primary care delivery structures, modes of practice and management styles?

Chapter 2 discussed evidence showing that a practice team approach to patient care - especially for patients with chronic disease – improves the quality and cost-effectiveness of service delivery. Evidence for the benefits of large, complex organisations moving away from highly centralised structure and management to greater devolvement of decision-making to the periphery and acknowledging the expertise and experience of frontline staff was also presented. A practice team model for primary care in Cape Town MDHS CHCs is proposed that draws from both these evidence-based developments in service delivery.

A partnership in health care, whether between an individual consumer and health professional or between health services (e.g. CHCs) and local communities, is a key component of quality care and is necessary to address health needs effectively. The opportunity to 'unlock hidden community resources' is denied when there is no collaboration.¹⁰⁶ The absence of sufficient CHC autonomy and the dependence on centralised organisation maintain a disconnection between local health needs and service delivery. These factors divert the energy needed for developing the service and improving patient care to satisfying central needs and are also likely to contribute to the frustration and dissatisfaction among staff and patients noted in this study and in reports on the service (Chapter 2). Patient flow in the CHC and patient allocation to doctors and CNPs are described in Chapter 3 under 'Usual process of patient allocation to doctors'.

Currently, real efforts are being made to devolve some management and decision-making functions from central (Head Office) to local structures (CHCs). Management training is now a requirement and personnel with management experience have recently been appointed as facility managers at each of the nine 24-hour CHCs. A facility manager will eventually be appointed to each CHC. In addition, a clinical manager role has been created at each CHC and experienced doctors (some with postgraduate training in family medicine) have been appointed to these positions. Trained family physicians are also being appointed to 24-hour CHCs to oversee quality assurance and the continuing professional development of staff as well as the expansion of current undergraduate and postgraduate family medicine training programmes in CHCs. These developments present real opportunities to implement the practice of the essential elements of primary care outlined in Chapter 1. However, an appropriate model for delivery is needed to

maximise the use of these opportunities and to operationalise the commitment to improved quality of care and health outcomes.

Advantages of a practice team model for CHC-based primary care delivery.

Muller⁹⁸ refers to the need for staff 'to translate their skills and knowledge into meaningful capital (to) give them more security and a better sense of mastery' (Muller (98):p.9).

Experienced, long-serving staff members have important knowledge of local communities. A practice team model will help to move away from focussing on staff weaknesses to capitalising instead on their strengths. Devolving key service activities to practice teams will affirm the expertise of clinical staff and counteract the feelings of failure and abandonment among staff by providing a new "container" for staff to exercise their clinical and other expertise and apply their knowledge of the community (Muller (98):p.3). Establishing practice teams will also help to identify staff training needs.

The practice team model has the potential to address a number of other problems.^{16,98} These include:

- unacceptably long waiting times (also noted in the MDHS Health Plan)⁸⁹;
- community dissatisfaction with the service;
- unresponsiveness to patients' needs among staff under stress;
- the disempowerment of staff due to a lack of decision-making powers;
- demotivated and demoralised staff;
- the alienation of management from staff and community.

A practice team approach has the potential to enable meaningful, therapeutic relationships to form between patients and a smaller team. Devolving care to practice teams will help to prevent the 'collusion of anonymity' that occurs when no one is designated with the responsibility for a patient's care.¹⁰⁷ Patients will experience more personalised care; staff will be able to develop a sense of ownership of the team and use their learning and expertise to develop the service.

Applying such learning is a normal part of the evolutionary process in well-functioning systems. Practice teams will create more career-pathing opportunities than at present. These features are likely to boost staff morale and may help to keep highly trained and experienced staff in the MDHS.

Practice teams will also provide role models and learning opportunities for undergraduate and postgraduate students in family medicine, nursing and rehabilitation sciences. (Family medicine registrar posts will be available in CHCs from 2007). Teams should be orientated toward health promotion and disease prevention as well as the role of continuity in risk behaviour change as an integral part of the consultation.¹⁰⁸

Essential features and functions of a practice team model

An appropriate model for effective primary care service delivery should be based on best practice, knowledge of the context of presenting illness, and respect for patients' preferences. It should reflect key features of well-functioning systems such as decentralisation of decision-making and management to the appropriate level in the service. The operation of the model should reflect the recognition of an appropriate degree of subsystem (CHC) autonomy and ensure the integration of important activities through proper central coordination. Arranging

CHC staff and primary care activities into practice teams may be a way to achieve this without much extra cost by using existing resources. A practice team would need to have a degree of autonomy (decentralised decision-making) balanced with accountability to a central co-ordinating structure (integration). Chapter 2 noted the call by Kane-Berman and Muller for improved utilisation of resources by re-engineering patient flow, clarification of the roles of medical staff and clinical nurse practitioners, for management to be more responsive to the workforce, and for decentralised decision-making for effective functioning of the service.¹⁶ These should be considered when deciding on interventions aimed at improving the quality and cost-effectiveness of service delivery.

In addition, an appropriate model for primary care delivery should:

- improve continuity of care and respond to patient preferences for continuity;
- improve the quality of care, reduce wastage and improve health outcomes;
- support other interventions aimed at reforming the health sector;
- reflect a shift in emphasis from diagnosis and treatment to maintaining and improving health;
- encourage initiative and greater autonomy in decision-making for frontline clinicians and managers as well as encourage appropriate patient responsibility for their health care;
- maximise opportunities for primary care professionals to apply their knowledge and training effectively in family and community-orientated primary care (in teams);
- help to achieve the appropriate team-based primary care skills mix needed for cost-effective care and efficient use of human resources, i.e. matching a clinical problem with an appropriate level of skill and training¹⁰⁹;
- function within current resource constraints, yet be acceptable to staff and patients.

Practice teams in South Africa

The staff of the Worcester CHC in the Western Cape is currently experimenting with a family practice team model (Dr H Conradie, family physician, Worcester CHC and Family Medicine Department, Health Sciences Faculty, Stellenbosch University - personal communication). The doctors and clinical nurse practitioners were grouped into two practice teams and patients were encouraged to register with a team for their ongoing care. The implementation process is currently being evaluated.

A practice team model was implemented at Ga-Rankuwa Academic Hospital in Gauteng Province some years ago. The hospital's general out-patient service was devolved to practices run by the Medical University of South Africa (MEDUNSA) Family Medicine Department. Former outpatient personnel were re-deployed to staff the practice teams. Each team operated from a separate practice building in the hospital grounds. These practices also served as teaching practices for undergraduate students and registrars in family medicine. (The impact of these practices on continuity has not been studied.)

Practices are the operational mechanism used elsewhere to deliver quality and cost-effective primary care in the public sector – such as in the United Kingdom. An essential requirement for the effectiveness of a practice model is that patients register with a practice and use the practice for their usual primary care needs.

Implementation: Practice team structure, operation and management

Practice teams can be formed by assigning doctors and nurse practitioners (and other staff depending on their availability) to two or more teams in large CHCs; patients would be allocated to and would register with a team. These processes would have to follow agreed criteria for allocation. (Patient allocation could be by area or ward in the community with care being taken to avoid undue disparities in demographic and disease profiles between practices.) Each practice team should provide for all its patients' primary care needs, using a comprehensive family and community-orientated approach.⁷⁶ The size and composition of a team would depend on the existing categories of staff available in the CHC as suggested in the focus group with clinical managers. There should be a core of permanent doctors and clinical nurse practitioners to maintain the coherence of the team and facilitate the practice of continuity of care.⁶⁹

Management of the facility, procurement, patient admission and allocation and record filing and retrieval would be coordinated centrally in the CHC in accordance with the central administration (Head Office) co-ordination functions. Options for practice-based dispensing of common medications¹¹⁰ should be considered to alleviate the heavy workload and long patient waiting times at CHC pharmacies. Pharmacies in the larger CHCs currently have a pharmacist and 2 or 3 pharmacy assistants. Allocation of assistants to practice teams while the pharmacist continues to have overall responsibility for procurement of drugs, training and quality control, is within the realm of possibility. Diagnostic and rehabilitation services such as radiography and physiotherapy would continue to be shared services.

Where staff are reluctant to join such a team, the formation of a more structured team can be left to a later stage of development. Initially a less threatening approach would be to colour code for two groups of clinical staff by assigning them one of two colours and similarly coding patient folders. This will reduce the number of different doctors and nurse practitioners a patient will interact with over time and so reduce the extent and results of fragmented care while avoiding the impact of sudden, big shifts in thinking and practice.

Practice teams should be allowed a degree of autonomy to respond innovatively to local health needs. Freedom to experiment with practice lists, doing house calls (not currently done), involving community health workers in the team, conducting primary care research etc, will provide more stimulation for clinical staff and improve patient care and the running of the service. Trained family practitioners in the MDHS are well placed to lead such teams. Practice teams have the potential to recognize and use more efficiently the clinical, research, practice management and leadership skills of trained family physicians. This, together with the career-pathing of family physicians through the introduction of family physician specialist posts, should reduce the high turnover of doctors in the MDHS. Similarly, nurse practitioner skills will be better used. Where family physicians are not present and where there is a high turnover of doctors, an experienced nurse practitioner could provide leadership and continuity in the team. As mentioned above, care will need to be taken to avoid undue disparities between practice teams. A tension between practice identity and initiative on the one hand and on the other hand the need for central co-ordination to avoid undue disparities is a healthy feature if managed well.

A practice team model could be taken a step further, where the infrastructure exists, by moving practice teams from CHCs into the community. Public sector family practices could be established in existing City of Cape Town clinics in the areas served by the CHC. Some of these clinics already provide comprehensive care for children and also dispense chronic care medication. A chronic care clinic in Guguletu run by an NGO (SACLA Health Project)* in collaboration with the Guguletu CHC has been well received by the local community.¹¹¹

Recommendations for further research

- determine the degree of CHC staff willingness and readiness to implement the model;
- determine the ability of practice teams to improve continuity and to reduce disparities in patient care⁴;
- identify ways to maximise personal continuity of care with a health professional and team while maintaining an element of patient choice⁴⁰;
- determine what the most appropriate team-based skills mix is for cost-effective care - i.e. determine the effect of different knowledge and skills inputs on outcomes¹⁰⁹;
- determine the cost of implementing the practice model and the potential savings from alleviating the negative effects of poor continuity;
- determine the ability of practice teams to improve the practice of all 4 elements of primary care outlined in Chapter 1.

* Now the registered name

The findings of this study and the practice team model should be presented to key stakeholders at selected sites with the view to implementing a pilot study at those CHCs. Opportunities should be sought to align the implementation of practice teams with the recommendations of the Kane-Berman report referred to in Chapters 2 and 5 and the goals of the Cape Town Metro District Health Plan 2004 – 2006⁸⁹ and the Western Cape Provincial Health Care 2010 Plan.¹⁰⁵ The need for change management consultants should be considered to help with management and staff orientation and to ensure adequate support during implementation. The pilot intervention should be monitored and evaluated using criteria agreed on by the key stakeholders. Evaluation should include determining patient and staff satisfaction with the model, determining any changes in disease control e.g. blood glucose levels and blood pressure, and an assessment of the impact on continuity of care.

5. CONCLUSION

The findings of this study share common ground with reports on investigations into primary care delivery in the Cape Town Metropole. There is evidence to suggest (Chapter 2) that some of the organisational and management problems noted in the reports may be addressed by a practice team model of delivery. In addition some of the positive outcomes associated with good continuity such as cost-effectiveness, improved quality of care and patient satisfaction, are goals set out in the Cape Town Metro District 2004 – 2006⁸⁹ and the Western Cape Provincial 2010¹⁰⁵ health plans. Better continuity is likely to facilitate the achievement of these and other important goals and to benefit the care of patients with chronic disease the most.

Current restructuring of the macro-elements of primary level services, such as community and district level health facilities, provide opportunities to consider the micro-elements of primary care and their impact on patient care and health outcomes (Chapter 1). A growing body of research provides evidence for a relationship between continuity of care, patient satisfaction, improved quality of care and better health outcomes (Chapter 2). Current restructuring should be accompanied by improvements to the process of care; the efforts being made to improve the service are opportunities to incorporate the four essential elements of primary care described by Starfield³ and to assess their impact on the process and outcomes of primary health care delivery. Attempts to improve the management of CHCs by appointing qualified personnel such as facility managers, clinical managers and family physicians to new management positions in the CHCs create a climate for restructuring along the lines of a practice team model. These developments suggest that management will be receptive to evidence-based approaches to patient care and service development.

It is easy to list recommendations and point to areas for further research. This may minimise the historical complexity that could undermine attempts at even simple interventions. Proposing more change may aggravate the current change fatigue prevalent among staff.⁹⁸ However, allowing the use of initiative acknowledges and affirms expertise and experience and has the potential to boost morale. CHC staff initiatives should be encouraged and supported by central administration with capacity building and co-ordination. A practice team model should be a vehicle for staff to use their own initiative to improve the service. It should facilitate service alignment with the goals of health sector reform and be able to function within current resource constraints.

Health and socioeconomic factors are constantly evolving. Health services should therefore be reviewed from time to time to ensure that they meet the changing needs of the populations they serve. Reviews should be seen as positive and as an opportunity to engage with all stakeholders to achieve the best possible outcomes with the resources available. They should be driven by internal motivation and not by external forces such as funding organisations.¹¹²

As the MDHS implements its health plan it should note the evidence linking the goals of its plan with the benefits of improved continuity of care. The MDHS should heed the call of the World Health Organisation and health systems researchers for good continuity in the management of chronic disease especially,^{113,21} and the pivotal role of well-trained generalists (family physicians) in improving health systems and achieving the goals of health sector reform.⁸ Policy makers should also take this into account when redesigning health care systems.

The principles of family medicine and its approach to primary health care are based on general systems theory. Family medicine in South Africa should do more to develop models of primary care delivery that reflect this. It has a responsibility to highlight the role of family physicians in improving the health of communities and to ensure the efficient use of resources. It is hoped that this study will contribute to this and the realisation of the goals of health sector reform in the Cape Town Metro District Health Services, as well as promote the values espoused in the South African Patients Rights Charter regarding patient care.⁹⁹

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Appendices

Appendix 1. Record audit

Appendix 2. Patient Questionnaire

Appendix 3. Patient Consent Form

Appendix 4. Focus Group Interview Guide

Appendix 5. Focus group participant information sheet

Appendix 6. Focus group consent form

University of Cape Town

CHC Record Audit

Primary care practice study: continuity

(1=Yes; 2=No; 3=Other)

1. Study number / CHC	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. Record number	<input type="text"/>			
4. Demographic information				
4.1 Gender	<input type="text"/>			
4.2 D.O.B.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.3 Area of residence	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Record details				
5.1 Date of first admission	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.2 Chronic illness (Htn, IHD, DM, Asthma, Epilepsy, Other) (Y / N)	<input type="text"/>			
5.3 Diagnosis (Chronic)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.4 Number of visits involving a doctor / CNP in the last 24 months	<input type="text"/>	<input type="text"/>		
5.5 Number of different doctors / CNPs seen in the last 6 consultations	<input type="text"/>	<input type="text"/>		
5.6 Max. no. of consultations (out of last 6) involving same doctor / CNP	<input type="text"/>			
6. Recorded details implying continuity arrangement (last 6 consults) (Y / N)				
6.1.1 Patient record: Return date	<input type="text"/>			
6.1.2 Dr / CNP surname	<input type="text"/>			
6.1.3 Other indication	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.1.4 Clinic card: Return date	<input type="text"/>			
6.1.5 Dr / CNP surname	<input type="text"/>			
6.1.6 Other indication	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Patient Questionnaire: Primary care research study

[1=Yes; 2=No; 3=D.Know]

1.1 Do you know the name of your diagnosis?

1.2 Agreement with record

2 Has a doctor / CNP specifically arranged to see you at follow up visits? (Y / N)

If yes, was the arrangement?

2.1 Verbal only? (Y/N)

2.2 Recorded on your hospital card? (Y/N) (verify & record in 4.8.4 of record audit)

2.3 Other

2.4 Do you know the doctor's / CNP's name? (Y/N)

2.5 Do you know his / her room number? (Y/N)

2.6 Approx. how many times have you seen the doctor / CNP in the last 6 visits?

2.7 Were your last 6 consultations for a primary care problem to this CHC? (Y/N)

2.8 If not, please specify

3 *Your views / preferences on continuity of care:*

3.1 Would you prefer to see the same (S) or different (D) doctors at each CHC visit? Don't mind which / no preference(M); Other (O)

3.2 Please give reasons for your answer (3.1).

3.3 Which factors may make it difficult to see the same doctor / CNP?

3.4 What will make it easier to see the same doctor / CNP - should you prefer it?

Consent form: Primary care research study

Family Medicine Division, Health Sciences Faculty
University of Cape Town

Patient consent for use of information in research study

Title: *Continuity of care* in Cape Town Community Health Centres (CHC). (Continuity means being seen by the same doctor or nurse when you visit the CHC.)

Study purpose

You are invited to participate in a health care research study being conducted by Dr Graham Bresick, Division of Family Medicine, Faculty of Health Sciences, University of Cape Town. The purpose of this study is to determine patients' views and experiences of continuity of care in Community Health Centres. It is intended that the information you provide be used to improve the quality of care for patients and families at health centres.

Study procedure

You will be asked by the attending health professional for your consent to allow the researcher to access your medical record. If you are selected as a study participant, you will be invited to participate in a focus group and / or a questionnaire survey. If you agree, you will be asked to sign a form indicating that you voluntarily consent to do so and to protect the information you provide and your right to confidentiality. (The questionnaire will take approximately 15 minutes to complete.)

Possible adverse effects

No adverse effects are anticipated. You may spend a longer time at the health centre than usual.

Possible benefits

You may benefit by expressing your views on an important aspect of the health care service. The aim of the study is to use the information gathered to improve the service for the benefit of all who use it.

Participants' Rights

Participation in this study is completely **voluntary**. You may choose not to participate or refuse to answer any question. If you decide to participate, you are free to change your mind and stop participating at any time. Your decisions regarding participation will not affect your relationship with staff or your health care at the centre negatively in any way. Regarding **confidentiality**, information you provide will be kept strictly confidential. Your name will not be included in the questionnaire. The consent form will not be linked to the questionnaire and will be kept in a secure file. Study information will not be entered in your medical record. Study reports or publications will not identify you in any way.

Any questions related to the study can be addressed to Dr Graham Bresick, telephone 021 406 6443/510. Questions about your rights as a study participant, comments or complaints about the study may also be addressed to the Ethics Review Committee, Faculty of Health Sciences, University of Cape Town, Observatory 7925, telephone 021 406 6492.

Patient consent to access his/her clinic record CHC / Study number

I understand the above details and my questions about the study have been answered. I have been given a copy of this consent form.

I hereby voluntarily consent to access of my clinic record for the purposes of this study.

Signature of participant

Date

Name of participant (printed)

Patient consent to involvement in questionnaire / group discussion

I hereby voluntarily agree to participate in the study questionnaire.

Signature of participant

Date

Name of participant (printed)

University of Cape Town

FOCUS GROUP INTERVIEW GUIDE

Participants: CHC Clinical Managers, MDHS

Facilitator: Ms Phyllis Orner, School of Public Health and Family Medicine

5th July 2005

Topic: Views regarding a practice team model to improve continuity of care and the quality of primary care in CHCs

1. **Given your knowledge and experience of working in CHCs, I'd like to know what your immediate ('gut') response is to the idea of CHC clinical staff working in smaller teams on an ongoing basis?**

Probe:

- What would you see as positive about this?
- What would you see as negative about this?

2. **I'd like to know more about your perceptions (or views) are about the idea of practice teams in CHCs.**

Probe:

In what ways do you think this will impact on staff cooperation?

- Why do you think they may not cooperate?
 - Feel "locked in"
 - Resistant to change
 - Too big a change
- Why do you think they will cooperate?

What are your thoughts about *team members* sharing the workload?

- Concerns about everybody "pulling their weight"?
 - If so, what would be the implications of this?

What are your feelings about implementing this model at this particular time?

- Too many changes already
- Have to cope with so much now
- There's too much going on

What are your thoughts about issues around team management or leadership?

- Good leadership or not so good leadership?
- Issues around training and orientation?

What would happen if teams "did their own thing"?

3. What advantages and disadvantages if any do you foresee if practice teams were implemented in your CHC?

Probe: What about:

- benefits for patient care
- staff and patient cooperation.....
- management of staff
- absenteeism
- staff turnover
- patient-staff relationships
- getting the work done

4. Now I'd like to know what difficulties you think may be encountered in the process of implementing a practice team model in your CHC?

Probe: What about

- the layout of the clinic (structural)
- current workloads (process)
- difficult staff members (attitudes)

If time allows and seems appropriate given the responses to above questions:

5. What do you think is has to be done before the practice team idea will be considered by staff?

or

How would you proceed (first steps) in getting to the point where staff may be willing to try a pilot exercise?)

Probe: What about

- staff support
- staff / orientation and training
- current management
- job descriptions
- community participation / buy-in.....

Information for focus group participants

Participants: CHC Clinical / Programme Managers, MDHS.

Facilitator: Ms Phyllis Orner, School of Public Health and Family Medicine,
Health Sciences Faculty, University of Cape Town.

MDHS, Woodstock Hospital Board Room, 4pm, 5th July 2005

Topic: Forming primary care practice teams in CHCs

The **main arguments** for a practice team approach to primary care delivery include the following:

- that large, complex organisations benefit from decentralising decision-making and management balanced with central co-ordination for effective functioning and delivery;
- that changes are needed in health service delivery for cost-effective chronic disease care; chronic care teams have been shown to be effective;
- that a continuing relationship (continuity of care) is fundamental to cost-effective and quality care; fragmented care (multiple providers) leads to wastage of resources and poor health outcomes;
- that patients prefer a continuing relationship with a primary care professional;
- that staff morale and work satisfaction may be improved by working in teams that recognise their professional knowledge and expertise and ability to make key decisions regarding the organisation of some aspects their work (within agreed norms and standards);
- that an appropriate mix of skills (e.g. doctor : nurse practitioner ratio) is necessary to ensure cost-effective primary care.

Forming practice teams is considered one approach to achieving these objectives, although this will need to be test in the MDHS context. The purpose of the focus group session is to identify and explore your views as clinical managers with respect on the idea of forming practice teams each with a core of doctors and CNPs (and possibly other staff categories) in the larger CHCs.

There may be a number of possible formulations of a team and these may vary from one CHC to another given current staffing and other factors. At this stage I'm not asking that you consider the specific composition of a team, the details of how it will function, and how patient allocation will be done - although these are important and also need to be addressed.

At this stage I'm interested in your views regarding key clinical staff (particularly, but not only, doctors and nurse practitioners) being placed in teams that work together on an ongoing basis to provide primary care for the patients / families allocated to them - i.e. allocated patients become the patients of a designated team that provides primary care for their new and existing health care needs.

Many thanks for your willingness to participate.

Graham Bresick

School of Public Health & Family Medicine Health Sciences Faculty University of Cape Town Email: gbresick@cormack.uct.ac.za Tel 021 406 6510/443; Fax 021 406 6667
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Focus group: Forming primary care practice teams in CHCs

(A study of continuity of care in four Cape Town Community Health Centres and ways to improve continuity)

5th July 2005

Consent form

The focus group is aimed at obtaining your views as outlined in the information sheet. Perhaps you feel there is already teamwork in your CHC and that nothing more is required. That's OK. The purpose here is not to decide what is or isn't, nor what is right or wrong. Given your experience, all opinions are valid. You will not be judged nor be made to feel uncomfortable. We are interested in your views whatever they are as you are not alone in holding them and they are important in the ongoing development of the service.

With your consent, we would like to tape record the interview. The results of the discussion will not in any way identify you, nor the CHC you're from. Any identifying information will be kept confidential and will not be included in the presentation of the results. The content of the discussion will be analysed for themes that emerge. Care will be taken where any quotations are used that they do not identify the source. It is not important for the study to know who said what but rather to identify important issues that are raised that need consideration when thinking about interventions to improve delivery as well as the satisfaction of staff and patients.

Your consent is required before participating in the session. You may withdraw consent at any time. Any questions related to the study can be addressed to Dr Graham Bresick, telephone 021 406 6443/510. Questions about your rights as a study participant, comments or complaints about the study may also be addressed to the Ethics Review Committee, Faculty of Health Sciences, University of Cape Town, Observatory 7925, telephone 021 406 6492.

I hereby voluntarily agree to participate in a tape recorded focus group session on the above topic as explained in the information sheet.

Participant's name:

Signature:

Date:

Dr Graham Bresick (Principle investigator) Ms Phyllis Orner (Group Facilitator) School of Public Health & Family Medicine Health Sciences Faculty University of Cape Town Email: gbresick@cormack.uct.ac.za Tel 021 406 6510/443; Fax 021 406 6667
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