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Cover Picture:
 John Hunter (1728 - 1793):
 founder of scientific surgery.
 (Refer to pages 196-198)

One-day primary care morbidity surveys: a feasible means for obtaining valuable healthcare services data

L G Goh

One-day primary care morbidity surveys have been carried out in many countries in the world. The National Ambulatory Medical Care Survey conducted annually in the USA reports the most common reasons for office visits to physicians. National morbidity surveys have also been carried out in the United Kingdom, Australia, Singapore, Hong Kong and Sri Lanka. In the Netherlands and France, such data were collected through computerised information systems⁽¹⁾.

These national surveys are a feasible means for obtaining valuable nation-wide data quickly. For such studies to be useful, a high participation rate is required. Publicity and appeal to co-operation and support for the national good is crucial for the success of any survey of this sort. The feasibility of one-day national morbidity surveys lies in the fact that it requires the efforts of all concerned but for only a single day.

The data obtained from such national surveys are useful for the monitoring of the health needs of the population, workload of healthcare providers, health planning policy, as well as the design of medical curricula. Such data collection exercises should therefore be a regular feature of healthcare delivery systems.

NATIONAL ONE-DAY MORBIDITY SURVEYS IN SINGAPORE

Emmanuel et al reports, in the current issue of this journal, results of the 2001 survey on primary medical care in Singapore⁽²⁾. This is a one-day national morbidity study, and is the third in the series. The first survey to capture information on practices and profiles in primary care was a national survey on outpatient morbidity carried out by the Ministry of Health, Singapore, in conjunction with the College of Family Physicians, Singapore, in 1988⁽³⁾. A second survey was conducted in 1993⁽⁴⁾.

The current survey was carried out on 21 August 2001. It provides valuable information on current primary medical care provision, morbidity profile and distribution of care in both the public and private sectors. By using a similar survey methodology to that of the 1993 national survey, the value of the 2001 survey is enhanced. Valid comparisons of workload, disease patterns, and distribution of disease profiles in the private and public sectors between the two survey years can be made.

The 2001 survey, like the 1993 survey, was a total sample study of general practitioners in private practice, and also of all doctors in the government polyclinics. There was adequate publicity by the major professional bodies. The Singapore Medical Association and the College of Family Physicians endorsed its support by generating letters signed by their Presidents. These letters were enclosed with the questionnaires sent to participating doctors. The Ministry of Health did likewise in terms of endorsement.

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The response rate from the general practitioners in private practice was 36%, and compared favourably with that of 31% achieved in the 1993 one-day morbidity survey. The polyclinics had a 100% return rate.

IMPORTANT CHANGES OVER TIME

The 2001 one-day morbidity survey results, when compared to the 1993 survey, showed important changes that healthcare providers and the Government should take note of.

Patient-load and related figures

There was a decrease in the average daily patient-load per doctor in the private sector, from 40 patients a day in 1993 to 33 patients a day in 2001. Also, during the same period, there was an increased number of doctors in private practice from 1,300 to 1,460. This was equivalent to a growth of 34% of the primary care manpower between 1993 and 2001.

The increase in manpower was matched by a much smaller increase in the number of patient attendances, from 18.01 million in 2001 compared to 16.58 million in 1993, which represented an 8.6% increase. The average number of visits per person to the primary care doctor in 2001 was 4.4, compared to 5.0 in 1993. Utilisation rate of services by children under 5 years of age was 6.6 visits per year, and that of the elderly was 6.5 visits per year.

What is also interesting is, despite the population growth of 25% from 3.3 million in 1993 to 4.1 million in 2001, the increase in primary care attendance was only 8.6%. This leads one to ask: Are primary care patients increasingly being taken care of by the specialist sector?

With the current medical class intake at 230 per year and an estimate of some 50% of each cohort joining the primary care sector, the number of patients seeing the general practitioner may further decrease over time. The implications of the patient-load and related figures therefore need to be studied in terms of medical class intake, new work, and sustainability of the primary care doctor.

Age group changes

Changes in attendances in the population subgroups may reflect changes in numbers of such patients or changes in distribution of patients across the providers. The percentage of patients under 5 years of age seen in all primary care clinics has dropped from 11.8% to 8.2%. The percentage of patients aged 65 years and over in all primary care clinics has increased from 6.9% to 9.3%.

The implications of the figures could again be studied further. For example, the number of elderly patients is increasing. Expertise of primary care doctors to take care of this rising sector of the population is needed. Medical care of old people (or geriatrics) cannot be extrapolated from adult medicine of the younger years that the medical practitioner is familiar with. The knowledge and skills to tackle the presentation and management of geriatric patients are a major area of growing professional needs that require addressing.

Chronic medical problems

As the population ages and infectious diseases come under control in developed countries, chronic medical problems will assume an increasingly greater importance in the work of the medical profession.

Indeed, the figures over the eight-year period from 1993 to 2001 reflect the increase in the numbers seeking care for chronic medical problems.

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The impact of affluence and adverse lifestyles will add to the numbers. Singapore is no exception.

Indeed, the figures over the eight-year period from 1993 to 2001 reflect the increase in the numbers seeking care for chronic medical problems. Correspondingly, the acute minor medical conditions will form a smaller proportion of the work of primary care doctor in the future. Thus, we see a decline of upper respiratory tract infections as a percentage of the workload in all primary care clinics, from 31.6% to 29.5% over the eight-year period. On the other hand, hypertension attendances have increased from 6.3% to 9.6% for all primary care clinics, and the corresponding figures for diabetes mellitus have increased from 3.0% to 3.9%.

The implications for healthcare are clear. The primary care doctor needs to hone his skills and promote his services to the public for care of chronic medical problems in order that he will contribute to reduction of the important disease burden in our community. He or she can do much to reduce the burden through preventive care, starting from early adulthood or younger. There is a lot of work that needs to be done to break the backbone of one important group of chronic medical problems, namely by preventing metabolic syndromes from ever taking root (e.g. diabetes mellitus, hypertension, hyperlipidemia, and obesity). The answer lies in the promotion of healthy and appropriate diet, exercise, and weight control to every person who visits his family doctor. Not all patients are expected to change their lifestyle habits immediately, but moving them closer to the stage of taking action as a strategy of stages of behavior change is worth all the efforts that need to be taken.

There is also a need for the primary care sector to negotiate and work with the hospital and specialist sectors in the provision of seamless care for those with chronic medical problems. The latter two groups of doctors should do what is regarded as its core work, namely, taking care of the difficult and complicated patients requiring the infrastructures of the hospital and specialist care setting. Only then, would the cost of healthcare be made cost-effective and bearable to the nation, family and individual.

CONCLUSION

In summary, one important message the one-day morbidity figures of 2001 and its corresponding figures for 1993 show to the primary care sector is this: as a corporate body, primary care needs to retool itself, to promote itself, and to negotiate with the hospital and specialist sectors on the apportioning of work in the care of chronic medical problems. There are, of course, other implications that the provider and administrator can see and should act on, based on a careful study of the 2001 Singapore one-day morbidity survey in its entirety. **SMJ**

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