ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

SSC5c Elective Report – Matthew Moate

Objective 1: Compare the prevalence and nature of psychiatric disorders at the main practice and the branch surgery. Discuss the differences between typical patterns of psychiatric disorders in this population as compared with populations in other developed countries and countries in the developing world.

I extracted data from the practice computer system based on diagnoses with read codes starting with E (mental disorders). The practice list sizes were 12473 for the main surgery and 1792 for the branch surgery. Of these, 6249 (50%) patients from the main surgery had ever had a diagnosis of a mental disorder, as had 713 (40%) of the patients at the branch surgery. The two main diagnoses at both surgeries were depression and anxiety disorders. The main surgery had 15% of patients diagnosed in each of these categories, whereas the branch surgery has only 10% of patients with anxiety disorders and 12.5% of patients with depression. The next most commonplace problems were eating disorders at the main surgery (4.41%) and sexual dysfunctions (2.96%) at the branch surgery. Baxter et al (2013) showed in a review and regression that anxiety disorders in European countries was 10.5% (7-15.5%), whereas in African countries it was markedly lower at 5.3% (3.5-8.1%).

I am not surprised at the lower levels of anxiety disorders amongst African countries than European countries, as this fits with my expectations of higher levels of self-reporting of anxiety amongst citizens of developed countries. However, I was surprised to see that lower levels of anxiety and depression were present at the branch surgery than at the main surgery. I was surprised by this as the branch surgery is in a comparatively deprived area, certainly relative to the main surgery, and I expected the pressures of deprivation to lead to worse mental health outcomes.

Objective 2: Compare the provision of healthcare in the UK under the NHS with healthcare models in other countries using the Bismarck model, the national insurance model and the out-of-pocket model.

In the UK, healthcare is provided primarily under the NHS with funding provided for through general taxation. Treatment is provided free at the point of care and is available to all, regardless of contribution. To a lesser degree, healthcare is also provided privately through voluntary health insurance schemes or out-of-pocket payments for services.

In Germany, the majority of people are enrolled into mandatory health insurance plans. These plans are funded through employee contributions, employer contributions and government subsidies to ensure access to healthcare for all. People earning more than 50,000 Euros per year are entitled to choose to opt out of the statutory health insurance and instead choose private health insurance. This model is sometimes called the Bismarck model, named after the German chancellor who introduced it.

In the United States healthcare is primarily provided for through private health insurance paid for by employers. Some people choose to pay for their own private health insurance, and others, such as the over 67s, veterans and public sector employees receive care provided for by the state. The health system in the United States does not provide healthcare to the entire population.

The out-of-pocket model describes a system whereby individuals pay for treatment as and when they receive it. An example of a nation where healthcare is primarily provided on an out-of-pocket basis is Sierra Leone. There is some healthcare provided through central taxation in Sierra Leone; this is for pregnant and breast feeding women and children under 5.

The Commonwealth Fund (2014) performed an analysis of different healthcare systems in developed countries. This measured health outcomes on several measures, such as quality care, access to care, efficiency, equity and healthy lives of citizens. According to their assessment, the UK ranked first overall, Germany fifth and USA eleventh of the eleven nations covered. A summary of their findings is shown in figure 1 below:

Figure 1: Commonwealth Fund (2014) Comparison of Healthcare Systems

Objective 3: I wish to work on the second cycle on an audit I previously worked on at the practice. This audit looked at NSAID prescribing for the over 75s within the practice. I want to see if any of my suggestions have been implemented, and if so, what effect these have had on prescribing.

I looked at patients aged over 75 currently taking an NSAID. N=75, range 75-96. The first cycle of the audit used the same criteria and N=76, Range =75-97. The most common NSAID was piroxicam (30), then ibuprofen (22) and naproxen (17). Two patients were taking diclofenac, with the remainder taking indometacin, ketoprofen or meloxicam. In the first round of the audit there had been 45 naproxen users and 27 ibuprofen users. This shows a shift away from the usage of naproxen and towards prioxicam.

43 of the patients were taking a PPI whilst taking their NSAID. This means 32 patients were receiving an NSAID without PPI cover. In the first cycle of the audit, only 15 patients went without PPI cover, suggesting the situation has worsened between cycles.

17 of the patients were taking both an NSAID and Aspirin simultaneously. This is a slight improvement on the 21 patients taking both drugs in the first cycle of the audit.

As with the first cycle of the audit, only five patients had a haemoglobin measurement four weeks after commencing their NSAID treatment. Only six patients were taking an SSRI alongside their NSAID, doubling the three from the first cycle of the audit.

Only 1 patient was prescribed an NSAID with a history of a peptic ulcer. The notes demonstrated that the ulcer had occurred several years ago and had been asymptomatic since. No patients had a previous history of GI bleeds. This is a considerable improvement on the first cycle of the audit in which 12 had a previous GI bleed and 10 had a previous ulcer.

With a similar sample size to the first cycle of the audit, there has been a marked improvement in not prescribing NSAIDs to patients with history of GI bleed or peptic ulcer and a worsening of prescribing of a covering PPI.

Objective 4: To practice my examination and history taking-skills with a view to becoming faster and more efficient at them. I currently find I progress through these tasks relatively slowly, and need to develop them in preparation for my upcoming employment.

Though I did not measure the amount of time I spent on these activities directly, I believe by the end of the placement I was seeing more patients in a session than at the beginning of the placement so I think I have made some progress towards achieving this objective.

References:

Baxter, A.J., Scott, K.M., Vos, T., and Whiteford, H.A., 2013. Global prevalence of anxiety disorders: a systematic review and meta-regression. Psychological Medicine, 43(05), pp 897-910.

The Commonwealth Fund, 2014. Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally. [online] Available at: <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror> [Accessed 8 May 2015].