

Defining the level and quality of care

For a long time, health service planners have grappled with the vexed question of how to provide care of optimal quality for patients in the most cost-effective way. When the large majority of healthcare-seeking customers suffer from conditions that are easily managed without expensive drugs or equipment by personnel without high levels of training or skill, it seems not to be cost-effective to place the highest level of skill and resources at the gateway. Accordingly, in a primary care-based model, patient services at the entry point into the healthcare system are planned at a relatively low level of sophistication and cost. The system is conceived as a funnel in which those few patients requiring more complex, expensive or skilled management will be identified and correctly distributed by referral or transfer into the next higher level of care, where decreasing numbers of beds and services are provided at an increasing level of sophistication and cost. This model applies comfortably to rural and district clinics and hospitals. Difficulties arise in such a system when there are deficiencies in skills or resources at the first level that preclude the identification, adequate management or timely referral of patients. Just as in casualty departments and emergency medical services, the skilled personnel should ideally be placed at the frontline, and in resuscitation, the most experienced operator should be the one to do the work. In such a situation, the patient's entry into the healthcare system could be compared to an inverted funnel or cone, where the patient gets referred to a lower level of care after initial skilled evaluation and costly care. The risk of such a scenario is that of over-servicing and excessive cost for the majority of patients.

The situation is rather more complicated in metropolitan areas where large hospitals could be expected to provide all levels of care in parallel, but where managers might expect clinicians to allocate patients to high-sophistication/high-cost care, or a lower, cheaper level of care, according to some system of definition. Westwood and colleagues show up some practical issues in their survey of patients in metropolitan Cape Town.

The definition of an appropriate level of care for patients is essentially required for resource allocation decisions. It might be said that it actually requires a high level of skill and experience to correctly define the appropriate level of care.

It is of the utmost importance that any given definition of level of care should not be confused with quality of care, health worker experience or skill. If a particular health professional happens to need advice or support with a patient's diagnosis or management, that does not necessarily define the case as needing a higher level of care, and numerous health professionals at level 1 facilities provide highly skilled services. The greater challenge lies in guaranteeing an adequate quality of care at each level of the system. That is a function of training and supervision.

In some ways, the principle of 'kangaroo mother care' discussed by Bergh and co-authors in this edition illustrates how neonatal and low-birth-weight care can become more cost-effective, safer and

more appropriate to resource-constrained environments without sacrificing quality of care. The principles of this low-tech approach are being introduced in neonatal units all over the world, and are helping mothers adapt better to the challenges of caring for premature and low-birth-weight babies even after discharge from supervised care.

This edition again features a number of interesting studies. Griessel and co-workers compared the attitudes of mothers to treatment decisions in neonatal care with those of medical and nursing staff, and found significant differences in the face of possible poor outcomes. Quite obviously, doctors cannot decide on difficult ethical choices on their own; beneficence considerations do not outweigh patient and parent autonomy.

Springer and colleagues wondered whether HIV-exposed but uninfected children of mothers with HIV were at an increased risk of neurodevelopmental handicap, compared with control children with HIV-uninfected mothers.

Lubbe presents an interesting report of a case in which expert opinion and suggestive investigations did not match the human dimensions of the case until the real diagnosis was unravelled; a salutary lesson indeed.

It is gratifying to note an increasing number of submissions to *SAJCH* from within this country as well as from elsewhere in Africa and beyond. The *Journal* is fully accredited and working towards wider recognition. Please continue to submit your contributions.



D F Wittenberg, MD, FCP (Paed) (SA)
Editor