Original paper

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Primary care bypass among psychiatric patients: A comparative analysis of primary and tertiary care mental health clinics in Ratnapura, Sri Lanka

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Abstract

Introduction

Bypassing primary care is costly to the patient and health care system. It leads to underutilization of resources in primary care and overcrowding of tertiary care institutions.

The present study investigated the reasons behind psychiatric patients' decision either to bypass primary care institutes or not to bypass when seeking psychiatric care.

Method

A qualitative study was conducted among the patients attending the Psychiatry Outreach Clinic, Divisional Hospital, Kiriella (DHK) and Psychiatric Outpatient clinic of Teaching Hospital Ratnapura (THR) using focus group discussions. All the participants were from the catchment area of DHK.

Results

Reasons for preference for primary care psychiatric clinic were proximity, low-cost transport, ability to attend the clinic with minimal obstruction to occupation, less crowded and familiarity of a local clinic.

The reasons given by the participants to bypass were uncertainty about medication availability, lack of investigation facilities and regular specialist care in primary care and higher frequency of clinics at the tertiary care facility. Majority of the participants from tertiary care facility were unaware of the existence of a psychiatric clinic at the primary care hospital.

Discussion

The findings indicate that observed primary care bypass could be due to patient unawareness about the service, perceived uncertainty about the availability of medication, investigations, and health care staff. Increasing awareness about the locally available services, ensuring regular medication supply and availability of basic investigation could make more people utilize primary care.

Limitations

A study limited to patients receiving state sector service will not be able to discern reasons for bypass among the patients who seek psychiatric care outside the government sector.

Keywords: primary care, psychiatry, health care bypass, tertiary care

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Introduction

Mental health disorders account for a significant proportion of the global burden of disease (1). In most parts of the world, mental health services are delivered in either institutional or community-based settings. Sri Lankan health system also caters to the mental health needs of the population via institution and community based system. The system addresses behavioral disorders that present acutely as well as follow up of patients.

One of the strategies accepted to optimize mental health care delivery is decentralizing the care. Sri Lanka implemented a decentralized mental health service in the late 2000s to reconfigure service provision from mainly an institution based care system to that is based on primary health care (2). The public health care system in Sri Lanka has two primary care arms; the Preventive Primary Health Care (Preventive PHC) providers based in Medical offices of Health and curative PHC providers (Curative PHC) based in Primary Medical Care Units (PMCUs) and Divisional Hospitals (DH). Latter in essence are PMCUs with inpatient capacity (3).

Primary care based services are traditionally expected to increase access to care, which could lead to better symptom control, increased patients' satisfaction and less out of pocket expenditure, which could eventually improve total quality of care and patient satisfaction.

Though the care delivery is decentralized, still a proportion of patients prefer tertiary care institutions based care over the primary care/community-based care. This bypass leads to underutilization of primary care and overcrowding of the tertiary care institutions, leading to negative effects on patients' outcomes at tertiary care level. There is also evidence that high patient loads contribute to cursory consultations at public sector facilities leading many patients to seek treatment from the private sector (4).

There has been extensive investigation into the phenomenon of bypassing of primary care specially amongst non-psychiatric populations, though studies from Sri Lanka are sparse. A study was done in Kegalle district in Sabaragamuwa Province to evaluate the first contact health care facility and accessibility found that proximity alone will not make people seek treatment from a particular facility. Most frequently visited facility by the households indicated that a high proportion had chosen a more distantly located one than the nearest available facility. Though the study alludes to lack of well demarcated draining areas and lack of clear referral policies causing bypassing, it was evident that patients who opted for the nearby government health services had to bear substantial costs for investigations and medications (4). In a study conducted in the outpatient department of Teaching Hospital, Karapitiya in Galle district in Southern Province in year 2019 reported poor quality of service provided by doctors, delays in service, lack of laboratory facilities and specialized services as the main reasons for patients bypassing their nearest health care institutions (5).

A report published by the Ministry of Health highlights the lack of a referral system and a back referral system as major causes for primary care bypass. The report also highlights that disorganized and unappealing primary health care, lack of investigations and imaging and the governments inability to afford to provide good quality facilities to primary health care as other reasons (7).

Present qualitative study was planned to evaluate the reasons for psychiatric outpatients bypassing primary care and choosing tertiary care as their preferred option and why other patients prefer primary care. As far as we know, no research has been done in Sri Lanka to evaluate reasons for bypassing primary psychiatry care.

Ethical approval for the study was obtained from the Ethics Committee of the National Institute of Mental Health and Ethics, Research, and Training Unit of the Ministry of Health in Sri Lanka.

Methodology

Study design

The study was conducted in the form of focus-group discussions among patients and family members or guardians who attended two outpatient mental health clinics in Ratnapura District in the Sabaragamuwa province of Sri Lanka.

Setting and participants

Kiriella Divisional Hospital mental health clinic in Ratnapura district was selected as the representing the primary health care setting, and the mental health clinic of Teaching Hospital, Ratnapura located 18 kilometers away served as the tertiary care setting for the study.

Kiriella is one of the seventeen Divisional Secretariats (DS) in Ratnapura District and has a geographical spread of 8100 hectares. The division consists of 17 Grama Niladhari Divisions and 35 rurals. The population according to last census was 35,650 belonging 9,970 families. 64 % of the families earned less than 20,000 LKR (Approximately USD 65) per month (8).

Divisional Hospital, Kiriella is under the Provincial Ministry of Health of the Sabaragamuwa Province while Teaching Hospital, Ratnapura (THR) is the largest tertiary care hospital in Sabaragamuwa province administered under the Ministry of Health, Nutrition and Indigenous Medicine of the Central government. THR provides specialized health care services to the Sabaragamuwa province. There is a 36 bed inpatient psychiatric unit at THR with specialist cover available round the clock. The outpatient psychiatric service of THR includes adult new patient clinics conducted twice a week and follow up clinics conducted three times a week.

Patients registered in two psychiatry clinics who were residents in the AGA division of Kiriella and aged more than 18 years were selected for the study. The selected were mentally stable at the time and were able to give voluntary consent. Only patients who had attended mental health clinics on at least three occasions were selected for the study. Informed written consent was obtained from all the participants.

The focus group discussions were conducted in the two institutions separately and tape recorded. There were 2-8 participants in each focus group. The language of discussion was Sinhalese. The place of discussions was the consultation/examination room of each mental health clinic. Each focus group discussion was conducted for 60-90 minutes as a single session. Participants were selected using a purposive sampling method. Patients from the Kiriella area who were also followed up at Teaching Hospital, Ratnapura over the same period were recruited into the study sample at THR.

Discussions were conducted by first author at the Psychiatry Clinic in Teaching Hospital, Ratnapura. Discussions in Divisional Hospital, Kiriella, were conducted by the second author who is a Medical Officer in Psychiatry from Base Hospital, Eheliyagoda, in the clinic room at Divisional Hospital, Kiriella.

Sample

Final sample was decided based on data saturation. The researchers continued collecting data until saturation was achieved. Interviews were guided by a prior decided outline of questions.

Data analysis

On completion of focus group discussions, notes and audio recorded data were transferred to a password-secured file. Audio recorded files were transferred to verbatim. Data was analyzed using both content and thematic analysis methods. Content analysis was utilized for extracting demographic and qualitative data. Thematic analysis explored overarching themes related to the study.

Results

Total sample description

There were 12 participants from THR and 34 from DH, Kiriella. Mean age of the participants was 55.3 years, with a standard deviation of 10.76 years. 48.5% were female. 69.7 % were married and 6% were divorced or separated.

DH, Kiriella sample

Income:

12.1% of participants had a fixed income and approximately 30.3% reported variable income. The majority, 54.5%, indicated having no income. While 25% of the participants relied solely on their own income, around 28% received support from their spouses and children. A significant portion, 37.5%, had support from other relatives while only 9.8%, received any Government welfare payments.

Illness variables:

The mean duration of illness from the onset was 19.24 years. (Range 01-45 years, SD 13.4) while 30.3% had received no inpatient care. The rest had at least one admission to inpatient services. Approximately 20% had received inpatient care more than 4 times in the past.

Clinic attendance:

About 45.5% of participants reported they had defaulted on clinic follow-up at least once in some point during their psychiatric history.

Reasons for bypass or not to bypass

The emerged themes that favored preference for primary care psychiatric clinic were proximity, low-cost transport, ability to attend clinic with minimal obstruction to occupation, less crowded and familiarity of the local clinic.

The reasons given by the participants at THR to bypass were uncertainty about medication availability, lack of investigation facilities and regular specialist care at primary care setting and higher frequency of clinics at THR. However, the majority (n=8) of the participants from THR were unaware of the existence of a psychiatric clinic at DHK.

Preference for local clinics over primary care facilities could be broadly categorized into four main Themes: proximity, low-cost transport, the ability to attend clinics with minimal obstruction to occupation, and the less crowded and familiar nature of local clinics.

Proximity as a decisive factor:

One of the prominent reasons highlighted by the participants is the issue of transport costs. The sentiment expressed in the phrase, *"If we had to travel to THR it would have further compounded our problems given the current situation in the country"* conveys the challenges and hassles associated with traveling to longer distances for psychiatric consultations in the midst of recent economic crisis. The preference for local clinics is deeply rooted in the convenience of proximity, suggesting that individuals are more inclined to seek mental health services when they are readily accessible close by.

Occupational considerations:

The participants further emphasized the financial implications of seeking healthcare in distant locations. The phrase expressed by one participant *"I could arrange the feed for my two cows and quickly come and attend the clinic and go back"* illustrates the interaction of daily life routine with the scheduled clinic attendance. The ability to attend a clinic with minimal disruption to one's occupation emerged as a critical factor. This suggests that individuals are more likely to attend mental health services when it minimally disrupts their livelihoods.

The participant's statement, *"I do a small business in the town nearby. Local clinic helps me to attend clinic without disruption of my income modality"* offers valuable insights into the relationship between individuals' occupations and their ability to attend clinics. The participant's statement, *"It is my daughter who accompanies me to the clinic. When my clinic is close by she can help me without disruption of her routine"* provides an illustration of how healthcare-seeking

behavior is facilitated with minimal obstruction to the family and caretakers' occupations when it is proximally available. In this particular scenario, the participant, a parent, describes the involvement of their daughter in the process of clinic attendance.

Less crowded and familiarity of the local clinic:

Final theme in patients' decision not to bypass primary care is grounded in the positive aspects associated with local clinics. The friendly nature of the local hospital and already established relationships with the staff is inferred from the positive feedback regarding the staff 's quality and the reputation of the District Medical Officer. "*I know the Chief Medical Officer of the local hospital. He is a good person*". *"Compared to Ratnapura, the patient numbers are less. We could get the treatment without wasting our time"*. The latter statement underscores the increased crowding in tertiary care that has led to many hours spent on follow up clinic attendance.

Furthermore, the participants' recognition of the local clinic as the nearest facility in emergencies underscores the practical benefits of proximity which was vocalized as *"This is the nearest hospital we have. They will do the needful in emergency and will transfer to Ratnapura if needed"* contributing to the perception of accessibility and reliability. The community's trust, as evidenced by the statement *"Many people in the village take medicine from this clinic"*, indicates a collective acceptance of local clinics, fostering a sense of community reliance on these healthcare institutions.

THR sample

The themes emerged among the group who decided to bypass primary care were in some ways unique. Eight (8) of the 12 individuals who participated were unaware of the existence of a follow up psychiatric clinic in their local hospital; "*We were not aware. We thought a small hospital like Kiriella would not have a specialized clinic"*. The other themes were related to comparative non availability of resources like regular medication supply, availability of investigations, regular specialist cover and option of inpatient care in the local hospital.

Uncertainty about medication availability:

Patients expressed concerns and uncertainties about the availability of necessary medications at the primary care clinic. This apprehension suggests a lack of confidence in the local clinic's ability to consistently stock essential medications. The participants may perceive the risk of medication unavailability as a potential barrier to receiving adequate and timely treatment for their health conditions.

Lack of investigation facilities and regular specialist care:

Participants highlighted the absence of comprehensive investigation facilities and regular access to specialist care at the primary care clinic. This points to a perceived limitation in the clinic's capacity to provide thorough diagnostic services and consultant psychiatrist services. The participants may be apprehensive about non availability of advanced medical resources and expertise that go beyond the capabilities of the primary care setting.

Higher frequency of clinics at THR:

The participants who bypassed identified a higher frequency of clinics at THR as a reason for bypass. This suggests that patients may prefer healthcare institutions that offer more regular and consistent medical services. The increased clinic frequency at THR may be perceived as an assurance of more accessible and timely healthcare, addressing concerns related to the availability of services.

Discussion

This qualitative investigation into primary care bypass among psychiatry patients within the catchment area of Kiriella in Ratnapura District Sabaragamuwa Province has identified several reasons for the phenomenon, though some are predictable and others are not.

The findings indicate that some patients bypass primary care due to the lack of awareness about available services. This is a finding that needs attention and further exploration. Unlike in private sector, government institutions are not in the habit of advertising the new services available in local hospitals and as a result it takes long time even for the people in the area to get to know about the local services. On the other hand, advertising has potential to draw patients in numbers that could overwhelm the capacity of the service. The latter possibility may reduce the enthusiasm among the free healthcare providers to advertise the services available. Perceived uncertainties regarding availability of medication is a fact that has been based on the experiences of people who access local healthcare facilities. Recent economic crisis is only one reason for the situation. Lack of surveillance for availability of medication and problems in supply lines also have contributed to the scenario. It is not uncommon to see the absence of enthusiasm for building infrastructure facilities to provide essential psychotropic agents. This situation has been valid for even tertiary care institutions (7). Availability of investigations and regular healthcare staff availability are reasons mentioned by some who choose to bypass. These reasons may not be always addressable given the hierarchical nature of the healthcare institutions and are neither cost effective.

It is also clear that a significant number actively choose not to bypass. Noteworthy factors contributing to

patients' decisions not to bypass include the proximity of local clinics, low-cost transport, the ability to attend clinics without obstructing daily occupations, and the less crowded and friendly nature of these facilities. The latter factors are clearly not related to the primary care facility's resources. It is also notable that relational aspects do not appear as a reason for attending the tertiary care facility, presumably because larger numbers prevent any meaningful relationships developed between the patient and doctor. Inter-personal quality of care is lacking in many of the public sector health care delivery settings in Sri Lanka and the decision to attend the service is related to basic delivery functions like availability of medications, investigations and regularity of service than the quality or personal trust (9). An additional reason for lack of therapeutic alliance in tertiary care is while in the primary care setting often one doctor sees the patient during each visit the doctor who sees the patient frequently changes in the tertiary care setting.

Limitations

A noteworthy limitation of these findings is that a proportion of residents in Kiriella catchment could be bypassing state sector altogether and seeking private sector psychiatric services. A study limited to patients receiving state sector service will not be able to discern reasons for bypass in this group.

Conclusions

This study indicates that at least in some instances primary care bypass could be due to patients being unaware about the services in the local primary care setting. This fact needs to be considered when expanding healthcare services in the country. State sector has traditionally lagged behind private sector in advertising the available services. While increased patient attendance could be an income generator for the private sector, the same is not true for the state sector. The commonly found other reasons for by passing are perceived non availability of medications, investigations and regular specialist care are demonstrated in this study as well.

While ensuring regular specialist care available in a Tertiary care setting is not a viable option for primary settings, ensuring availability of regular medications and common investigations are within the capabilities of provincial health care services. Investing in these lines could lead to lessening the crowding of clinics in tertiary care settings with improved patient satisfaction, lessening 'the time wasting' as described by one participant. Interestingly interpersonal nature of the interactions didn't emerge as a theme at the THR indicating the limited time available in a crowded clinic to develop meaningful therapeutic alliance. Cost of medications for example can take priority concern for patients over therapeutic alliance when poor.

We think these themes could be valid for psychiatric service provision in different parts of the country and comparable health service delivery systems in other parts of the world as well.

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Statement of contribution

VID conceived, designed the study and conducted the focus group discussions at THR. MLLS did the literature search and conducted the focus group discussion at DHK. SKAS, HMNPK and UPANU were involved in analyzing the qualitative data. VID and MLLS wrote the manuscript. All authors read and approved the final version.

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