

JAMAICA, INTRA II

Perceptions of Health Care Providers - The Training Issue

Denise Eldemire-Shearer, The Jamaican Team,
Ageing and Life Course Program, WHO Geneva

Introduction

The argument for increasing health promoting messages for older persons is getting stronger as an increasing number of studies provide evidence that there can be a reduction in ill health and disability in older persons¹. Lifestyle and behaviour play a significant role in the development of chronic conditions such as heart disease, diabetes, and cerebro-vascular disease through unhealthy behaviour and patterns of consumption. There is evidence from studies of the impact of self-management on reducing disease and disability¹.

The primary health care system which provides many persons with the first step in interactions between a client and the health delivery system is in a unique position to make an impact. For there to be an impact patients and health care workers must develop quality relationships which persist and grow over time. Health care workers should ensure that patients have adequate knowledge, skills and attitudes to manage their conditions. For this to occur, the health care worker also needs adequate knowledge, skills and attitudes, a conducive environment and adequate time. Unfortunately in many instances this is not the situation. The primary health care system provides an excellent opportunity for applying the life course perspective.

Many health care systems are organized around acute care systems and are modeled off the Maternal and Child Health (MCH) model. Visits are assumed to be discrete face to face interactions on a specific problem - the presenting complaint. There will need to be a shift from this crisis type management to a more interactive long-term management approach.

Health Promotion and the Older Person

The need to shift away from focussing on disease, illness and death when approaching health of older persons has led to a discussion of specific techniques to be applied in health promotion for older persons². It should also be recognized that some elements in the learning environment are hostile to this concept. The discriminatory and ageist attitudes sometimes encountered during client-provider interactions need to be recognized and addressed in subsequent programmes. The common views *that "old age means sickness" and "old people cannot change"* are good examples.

Instead of focussing on curing disease and preventing death there may be benefits from looking at healthy older people as to how they stay healthy and how this can be facilitated and promoted. This view calls for a paradigm shift in several areas including shifting from the acute care model and viewing persons along a continuum from well to diseased.

Persons are also part of their environment, family environs, social and environmental including relationships, interactions and supports. An approach promoting wellness would draw on these resources.

The life course perspective and the new public health approach both embrace a health promotion approach. The Ottawa Charter provides five (5) elements:

1. Strengthening community action
2. Developing personal skills
3. Enabling, mediating and advocating
4. Creating supportive environments
5. Reorienting health services

In terms of older persons, the focus should be on:

1. chronic disease and disability, self care and management
2. community based approaches and initiatives
3. poverty alleviation
4. addressing social justice and inequities where they exist
5. reorienting primary health care services
6. inter-sectoral approach and coordination

The shift on responsibility is now from the health care professional to the individual. To achieve health promotion for older persons a number of strategies have been tried by national programmes.

These include

1. educational activities for seniors
2. supported by adequate information and materials
3. public awareness campaigns
4. collaboration

Health promotion in older persons has three (3) elements including health protection, prevention - specific measures to deal with disease and as usual is divided into three (3) levels primary, secondary, tertiary and education. Health Education focuses on information and advice giving and for older persons it is on health preservation, that is, maintaining maximum function.

From a training perspective this study intends to describe the health care worker/senior interaction and to identify if it needs improvement and how.

Method

Three (3) activities contributed to the findings

1. The community based survey of workers in the primary care system
2. Focus groups with providers
3. Feedback discussion sessions with individual groups of healthcare workers

Results

Sample Population of Health Workers in Health Centres

- 86 professionals ranging in age from 21 to 61 were interviewed, representing all the health centre staff for the Parish studied.
- 30% were under 35 and 50% between 35 and 50.
- Mean of 40 and mode of 48.
- 64% were Community Health Aids.
- 21% were Nurses.
- 10.5% Doctors.

The length of service was equally divided.

- $\frac{1}{3}$ less than 5 years
- $\frac{1}{3}$ 5-10 years
- $\frac{1}{3}$ over 10 years

The distribution and characteristics of the study area for staff was similar to those for other areas of the island.

The data was analyzed according to professional category and length of service. There were only three males, all Doctors, so a gender analysis was not done.

Sample Characteristics

- The majority (90.6%) said they were generalists.
- All reported having patient contact.
- All doctors worked less than 5 years in a health centre.
- Focus group responses with Doctors indicated that the majority had worked in hospitals previously and were not planning to remain in Primary Health Care but were waiting to be admitted to specialty training programmes.
- In the patient analyses Community Health Aids were not identified as providing information.

Length of Service

All Doctors had less than five (5) years service.

- 41.2% Nurses and 24.1% Community Health Aids had less than 5 years.
- 23.5% Nurses and 38.9% Community Health Aids 5-10 years.
- 35.3% Nurses and 37% Community Health Aids over 10 years.

Length of service at the same Health Centre suggested a rotation of Nurses as:

- 66.7% had spent less than 5 years at their current Health Centres.
- Only 22.2% over 10 years.

Community Health Aids seemed to move less as:

- 44.4% had 5-10 years.
- 29.6% over 10 years.

Perceptions

The staff in general reported enjoying their work with the elderly.

- 58.2% said as enjoyable as others.
- 38.2% said more enjoyable.
- Nurses 44.4% and Community Health Aids 41.7% said enjoyed more compared to only 11.1% of Doctors.

Other views and opinions however emerged from the same staff in the focus groups. Persons working in Health Centers for more than 10 years were more positive with 63% saying more enjoyable.

Staff felt they communicated well with the elderly.

- 45.2% said well
- 53.6% very well.
- Doctors were more conservative, 77.8% saying well (us very well - 22.2%) compared to 33.3% nurses and 45.5% Community Health Aids.

However as the length of service increased persons associated their improved communication skills with this.

- 77.8% of those with over 10 years said very well.

Table 1: Communication with Elderly by Length of Service

	<5	5-10	10+	
Little	3.4			1.2
Well	55.4	57.1	22.6	45.2
Very Well	41.4	42.9	77.8	53.6
Total	34.4	33.3	32.1	

Table 2: Communication by Profession

	Doctor	Nurse	CHA	
Little			1.8	1.2
Well	77.8	33.3	45.5	45.9
Very Well	22.2	66.7	52.7	52.9
Total	10.6	21.2	64.7	3

Practice

Staff did not always make sure they were understood.

- Less than 50% (49.4%) said always.
- Lowest response rates were recorded for doctors.

Table 3: Assessment of understanding by Profession

	Doctor	Nurses	CHA	
Always	25.0	56.3	54.7	50.0
Occasionally		12.5	15.1	12.5
Never			1.9	1.3
Frequently	7.5	31.3	28.3	36.3
Total	10	20	66.3	100

Table 4: Answers varied with length of Service

	<5	5-10	10+	
Always	36	46.4	65.4	49.4
Occasionally	16.0	10.7	11.5	12.7
Never		3.6		1.3
Frequently	48.0	39.3	23.1	36.7
Total	31.6	35.4	32.9	100

Reasons for the replies were probed in focus groups and inadequate time for the large numbers was the most common reason cited.

Only a small percentage 13.5% said never or occasionally and gave three answers including: because of their facial expression, their answer and assumed they understand.

- 44.2% encouraged patients to ask questions
- 43% said frequently

- 12.8% said occasionally
- No one said never
- Of the 11 persons responding occasionally only 7 gave a reason and the answers were vague.

Answers varied according to the years of Service.

Table 5: Asked if understood by Service

	<5	5-10	10	
Always	36	46.4	65.4	49.4
Occasionally	16	10.7	11.5	12.7
Never		3.6		1.3
Frequently	48	39.3	23.1	36.7
Total	31.6	35.4	32.9	

Table 6: Asked if understood by Service and Profession

	<5	5-10	10	
Always	25	56.3	54.7	50
Occasionally		12.5	15.1	10.5
Never			1.9	1.3
Frequently	75	31.3	28.5	36.3
Total	10	16	66.3	

Lifestyle Factors

Staff were asked to identify these practices with regard to questioning patients at the first consultation. The majority responded that they did and the results are presented below. It is important to note the difference in answers given here between the staff and patients. Patients having previously (Questionnaires A & B) reported much lower levels of questioning than as reported by staff. An observational study is needed to clarify this area.

Smoking

- 88.1% reported asking about smoking.
- Only 19% said always.
- Doctors (55.6%) were more likely to always ask compared to Nurses (16.7%) saying always.
- All (98.9%) reported advising against smoking.
- 57.1% always.
- 41.7% sometimes.

Diet

- 41.7% reported always asking about diet.
- 57% sometimes.
- Doctors (44.4%) were more likely than Nurses (27.8%) to always ask but similar to Community Health Aids (45.5%).
- Length of service did increase the number always asking.

Table 7: Questions about diet

	<5	5-10	10+	
Always	34.5	30.8	55.6	41.7
Sometimes	65.5	69.2	44.6	57.0

Physical Activity

Answers to this topic were considerably lower.

- 20.5% reported always asking.
- 12.8% reported never.
- Responses matched those given by patients.
- Patterns by profession were consistent.
- Length of service did not influence the results.

Alcohol

Response for alcohol were similar to those for physical activity - low.

- 22.9% always asked.
- 69.9% sometimes.
- Patterns by profession were consistent.
- Length of service did not influence the results.

Note: The number of persons reporting never asking the lifestyle questions was low so the answers as to why not did provide useful information. It would have been interesting to know why the majority reported only asking sometimes.

Staff was then asked if they reinforced the importance of lifestyle modifications at each visit. The replies were similar to those obtained for the previous section.

Table 8: Lifestyle factors

	Always	Sometimes	Never
Smoking	36.0	57	7
Diet	53.5	38.4	8.1
Physical Activity	34.2	59.3	6.6
ROH	39.7	54.4	5.4

As seen in Table 8, answers were most positive as they relate to the question on diet.

- 75% of Doctors reported always asking about diet compared to 37.5% about smoking.
- 42.9% about exercise.
- 57.1% about alcohol.

The question about physical activity was influenced by length of service as more persons with over 10 years asked about it, increasing from

- 23.1% with under 5 years always asking to 55.6% with over 10 years.

The other three areas showed similar answers for each length of service.

Key messages did not vary much.

Smoking

- 63.3% - stop smoking.
- 16.5% - smoking is bad for lungs.
- 13.9% - smoking is bad for health.
- There were no differences by profession.

Diet

- 59.5% - stick to diet.
- 29.1% eat less, less fat and salt.
- Doctors (50%) were more likely to say eat less.
- Nurses (50%), stick to diet.
- 78.2% - exercise in moderation.
- 14.1% - exercise is good for your health
- There were no differences by profession.

Alcohol

- 64.2% - drink in moderation.
- 23.9% - bad for health.
- There were no differences by profession.

Depression is increasingly being recognized as an important area of concern, yet only 7.2% reported screening for depression.

Table 9: Depression Screen

Always	7.2%
Frequently	31.3%
Occasionally	53.0%
Never	8.4%

Interestingly, Nurses reported higher levels, than Doctors, of questioning. Nurses (42.3%) frequently compared to Doctors (28.5%).

Training and Education

Staff reported varying degrees of education and training on specific topics

Table 10: Received Preventive Education by Illness and Profession

	Doctors	Nurses	CHA
Hypertension	88.9	88.2	82.3
Diabetes	100	94.1	88.7
Hypercholesterol	88.9	52.9	17.0
Obesity	77.8	76.5	54.5
Stroke	77.8	76.5	30.8
Heart	88.9	70.6	29.4

Of note are the low levels of Nurses and Community Health Aids reporting training on cholesterol prevention. Community Health Aids in general reported less training on all topics than other health staff despite having more contracts with elders than other categories.

Table 11: Diagnosis Education by Illness & Profession

	Doctors	Nurses	CHA
Hypertension	88.9	62.5	72
Diabetes	100	62.5	70
Hypercholesterol	88.9	50	12.8
Obesity	77.8	62.5	37.5
Stroke	88.9	56.3	23.4
Heart	88.9	56.3	20.8

Length of service did not affect the responses significantly but surprisingly increased length of service did not increase the response rate as to whether or not the staff member had received training as it pertains to an illness.

Norms and Guidelines

- 83.7% reported norms and guidelines for the management of hypertension in general.
- 68.6% specifically for seniors.
- There were professional differences as 100% of both Doctors and Nurses reported guidelines.
- Doctors (88.9%), Nurses (66.7%) reported guidelines for seniors.
- 53.5% reported getting any training on norms and guidelines.
- There were differences by profession as Doctors (77.8%), Nurses (66.7%) reported receiving training, which is still relatively low. Similarly low numbers reported (62.8%) applying them. This was due to the Community Health Aids response.
- 100% Doctors and Nurses reported applying this.

The staff was asked to identify their own perception as to why seniors do not follow instructions. The negative perception of seniors having no will was the predominant response.

Table 12: Staff perceptions of Seniors

	NO Will
Smoking	47.1
Diet	45.2
Physical Activity	68.3
ROH	57.5

This was particularly so for Nurses and Doctors, Community Health Aids responses were more varied and place equal emphasis on family problems as a reasons. The perception of seniors having no will to change may be an explanation for the lower levels of questioning and advising patients reported by the patients.

Responses as to why seniors did not follow instructions were varied.

Table 13: Instructions not generally followed

Lack of trust	3.3%
Low education	16.1%
Do not understand	14.7%
Bad memory	14.4%
No will	15.3%
Family problems	12.5%
Economic problems	21.4%
Other	11.5%

Once again, the responses as to why they did not follow instructions as it relates to medications varied.

Table 14: Instructions not generally followed about medications

Lack of confidence	48.8%
Asymptomatic	82.6%
Not convinced	58.1%
Forget	83.7%
Finance	89.9%
Side effects	61.6%
Prefer alternative	65.1%
Medication not available	31.4%

- Doctors were more positive about seniors changing lifestyle, 88.9% saying they could.
- Nurses (68.8%) and Community Health Aids (51%) were less positive about seniors changing their lifestyles.

Staff was divided on their perceptions of their health centres as promoting behaviour change among the seniors.

Table 15: Health centre as promoting behaviour change

	Doctors	Nurses	CHA	Total
Very Effective	11.1%	11.1%	28.3%	22.9%
Quite Effective	44.4%	27.8%	34.0%	34.9%
Little Effect	44.4%	55.6%	35.8%	39.8%
Not at all		5.6%	1.9%	2.4%

Discussion

The data clearly indicates a lack of adequate practice of prevention with clinic attendees. A number of reasons were identified some having to do with attitude other to do with conditions in the clinic. In follow up discussions, group health providers also identified the lack of training materials and health promotion materials, which target seniors and have identifiable messages. They cited the many child-related posters available for gastro and nutrition as examples.

Seniors themselves do not always understand the relevance of prevention and rely on home remedies using formal health services as a last resort.

The scope of training needed is therefore very broad involving seniors as well as health care providers. Training will need to start by providing information on ageing itself and helping persons change current perceptions. Once that has been done, specific age related information would need to be taught.

The curricula and training materials to be developed alongside the training. A possible link for this activity is the Master of Public Health (Health Education/Promotion) Track offered at the University of the West Indies so that materials could be developed, tested and adjusted. Small behaviour change studies would be needed to identify what influences the seniors most to identify and change a behaviour. The elements of the Ottawa Charter could be used as a basis.

The findings support the need for more work as persons thought they communicated well but yet weren't giving the needed prevention information. The efforts at education and training will have to be supported by some changes in the clinic in order to facilitate the educating process. The present system does not allow for much time to be spent educating the senior. Studies have shown that with some of the sensory impairments additional time per session and additional sessions are needed to effect behaviour change in seniors.

Follow up sessions have also indicated that the health care workers would be responsive to such training, which is very reassuring.

In conclusion, training and retraining both health care providers and seniors will need to be an important pillar of any effort to improve the health care system for seniors.