CIRCULATION

SA Family Practice is received regularly by subscribers and members of the SA Academy of Family Practice/Primary Care. Non-members who wish to ensure regular receipt of the journal may subscribe (see Subscriptions). Non-members may however receive the journal but regularity is not assured.

JOURNAL POLICY

SA Family Practice is published monthly by the SA Academy of Family Practice/Primary Care.
It offers a voice to local family practice, placing original contributions from the research of family practitioners/primary health care workers as a priority. It aims at stimulating original research amongst family practitioners. The length of articles should preferably not exceed 2 000 words. References should be used in SA Family Practice according to the Vancouver system. Three copies of a contribution, typed in double spacing should be submitted. Articles will be sent to expert referees before acceptance for publication. The Journal also has an update or continuing education section, placing review articles that take cognisance of the information needs and frames of reference of primary health care clinicians. SA Family Practice further serves as the mouthpiece of the Academy. As such, meetings are reported on, along with other news. Special topics are discussed in Forum, and future events are published.

Member of the Audit Bureau of Circulations of South Africa

Member of Specialist Press Association

ISSN 1025-1979

editorial

MANAGED CARE: A SLIPPERY SLOPE?

The Academy of Family Practice has as one of its main concerns the standard of care that is available to the whole population of South Africa.

If your understanding of good practice is merely the amount of money you make, don't bother to read on.

There is no way in which we can practice a high standard of care without adequate management. To date much of the managing has come from within the professionals, from our personal and professional ethics and discipline. We have been brought up in a society where it was accepted that you wake up at night when called by a patient, that you remain available for your patients and that fraud is unacceptable.

As soon as the management from within diminishes the management from without has to take up the slack if we are to avoid the total collapse of the health care system. This applies equally to the systems of the state and the private sector. The chief temptation of the fee for service sector is to overservice. The chief temptation of managed care is to underservice. The public sector has the same temptation to underserve.

Both the private and public sectors have enough people in the system today who do not have the self discipline that will allow our country to have affordable health care. The public sector has become non-functional with its non-system of yesteryear. The private sector is incapable of sustaining its viability. Both systems can only be salvaged on behalf of the survival of the patient with increased management from the outside of the professional. If we can get back to a way of conducting ourselves in such a manner that the patient gets affordable care of quality then we will again be acting in our own best interests as professionals.

Managed care and HMOs is just one of the ways of trying to salvage the situation we are in. It is quite capable of both decreasing and increasing the standards of medicine we practice. Our protection lies in setting up systems where the self-interest of patients, health workers and payers are fairly balanced against one another so that real negotiations can take place between equals. The middlemen between these parties sucking off profit without adding much value, should be as few as possible.