

Survival has many meanings

The account was from a fellow GP. It was for an upper respiratory illness in a fit ambulatory patient who felt a little inconvenienced by the illness. The amount of the bill was R523,00. The bulk of the amount was for medication. Yes, it was a dispensing doctor and the patient was on a medical plan. Yes, the doctor had suffered from the collapse of the MCG medical aid scheme, "after all one has to make a living".

The previous day we were discussing the situation in Angola and Mozambique. For those who have forgotten, these two countries are close to us, from the one there is still a substantial number of refugees and 'immigrants' in South Africa. In Angola the state pays a doctor about US\$5,00 per month. They do not expect the doctor to live from that as everyone knows that he can just get enough food for one day for that amount. In Mozambique it is different. A doctor gets about US\$200,00 a month and is expected to work a 20-hour week for the state. For the rest private practice or some other activity is encouraged for the purposes of making a fair living.

We are in the process of negotiating our own future and I want to look at a few of the temptations of different alternatives. Some may label them opportunities or incentives!

The temptation of a salaried doctor is to do as little as possible as the salary is fixed even if your productivity is zero. You just have to stay unnoticed. Last week a medical superintendent told me that in his hospital doctors planned their work to fit into a five-hour day. If all or most

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doctors do this in a large hospital there is very little the superintendent or the state can do to change it. If you are employed by a local authority as a doctor or a small organisation on a salary, then it's more difficult. You can't just disappear. Everywhere I move, however, the same song is sung. We are very short-staffed and working under too much pressure.

On the other hand, if the same person was in private fee-for-service practice they become very anxious when things get slack. If there are no patients left when the shadows start to lengthen the groans are, "practice is really no longer worth it". Listening to the small talk, it seems that in this group of practitioners there are many that feel they are not surviving. Perhaps the bankruptcy is just at a higher turnover, or is this all about something else that has very little to do with money?

In a capitation system there is also a fixed income. If the doctor is getting a fixed salary he will be tempted in the same fashion as described above, but will probably have more constraints as someone is going to be there to manage his behaviour. If the doctor is receiving the capitation directly she will be tempted to do as little as possible, as cheaply as possible, to maximise income. This only works in the short term if this is pursued to the detriment of the patients' health, the need for care will increase and the responsibility will not be able to be avoided.

There are temptations in every system. Our task is to choose a system or mix of systems that will promote efficacy and productivity without jeopardising the survival of health workers or patients. Let's find some scheme that will tempt us to do the best for ourselves and our patients.

Sam Johnson