medico-POLITICAL

RESPONSE TO THE ANC DOCUMENT A National Health Plan for South Africa

We wish to state clearly that we support the broad principles outlined in this document ie the establishment of a healthy environment; providing accessible healthcare for the entire population; improving the mental health of the population and making communities part of the decision-making process on matters affecting their health. We will work actively to pursue and to promote these goals among our members.

We have analysed the ANC Health Document under the relevant headings as they appear in the document and have made comments and recommendations where we felt these necessary.

We would like all the comments which are made in our response to be understood in the light of an attempt at a constructive contribution towards helping the ANC in the development of its Health Policy for our country. The Academy is fully committed towards giving its full assistance in the development of a PHC Policy in the interest of all South Africans and we offer our resources in training, expertise and goodwill to this end. We look forward to the opportunity to work closely with a new Health Department in this regard and trust that this paper will be followed by ongoing contact and dialogue.

A. Foreword

"The apartheid health system has also been biased towards domination by doctors". While fully acknowledging the vital roles to be played by all members of the Health team, we are concerned that this statement could detract from the valuable contribution which has (and hopefully will continue) to be made by PHC professionals. Specifically, as far as the Academy is concerned, the expertise of the family physician could be utilised not only in helping to provide a high quality of PHC to all members of our society, but also in helping to train other members of the health team to function optimally.

Lack of intersectorial co-ordination in health programmes results in duplication

Another statement which we found inappropriate was "the recognition of a distinctive role in health prevention and protection for communities and patients is totally alien to the traditional thinking". As an Academy, this "distinctive role" is far from alien to us. Perhaps the statement was influenced by observations of the curative emphasis in traditional medical schools but which we, as an academy, are striving to redress and follow the guidelines given, inter alia by John Fry (1977 "Trends in General Practice") who gave the following description.

"The Family Practitioner (FP)/Primary care doctor provides personal, primary and continuing medical care to individuals, families and a practice population irrespective of age, sex and illness. He/She will attend to patients in the consulting room and in their homes and sometimes in a clinic or hospital. The aim is to make early diagnoses. He/She will include and integrate physical, psychological and social factors in his/her consideration about health and illness. He/She will make an initial decision about every problem which is presented to him/her. He/She will undertake the continuing management of his/her patients with chronic, recurrent or terminal illnesses. He/She will practice in co-operation with other colleagues, medical and non-medical. He/She will know how and when to intervene through treatment, prevention and education to promote the health of his/her patients and their families. He/She will recognise that that he/she also has a professional responsibility to the community".

B. Health Vision

The aim to provide more accessible healthcare facilities is an admirable one and we suggest the following improvements to the present system.

1. All clinics will have to review their operating hours to become more user-friendly.

2. Day Hospitals need extra staff to cope with the workload. There is also a need in this situation for a CME programme which should be mandatory for all staff.

3. Local doctors should be offered sessions at clinics, Day Hospitals or District Hospitals and should be encouraged to treat their own patients in hospitals rather than referring for expensive specialist care.

4. That administrative staff at all municipal and State clinics be "retrained" to understand that the facilities which they are staffing do not belong to them but to all the taxpayers of this country. They are the patient"s point of first contact with a hospital and they should be taught to treat people with dignity and respect.

5. We are in complete agreement that "Primary healthcare offers the only viable alternative for sustainable and equitable health development. The primary health care level will be the first level of contact of individuals, the family and the community with the NHS".

It is thus very important that there is appropriate training of Family Practitioners whether in the

public or private sector.

We believe that to achieve the aim of "Healthy people in a healthy environment", the following have to be addressed:

(a) Proper housing, running water and sanitation facilities.
(b) Maintainance of a clean environment and educating people with regard to the benefits of basic hygiene.
(c) Community facilities such as créches, pre-school facilities, youth and senior citizen centres for recreation.
(d) Educational programmes on the rights and obligations of citizens. An informed community will be a more co-operative community.
(e) Controlling of criminal activities especially in the townships.
(f) A good transport system free of thugs and gangs.
(g) Other intersectoral collaboration.

In general, all the above would contribute to a better health for the population. Lack of intersectoral co-ordination in health programmes results in duplication and this in turn increases costs at all levels. The Conference of Alma Ata recommended that National Health policies and plans take full account of the inputs of other sectors bearing on health; that specific and workable arrangements be made at all levels – in particular at the intermediate and community levels – for the co-ordination of health services with all other activities contributing to health promotion and Primary Health Care.

C. Health Policies

(1) National Drug Policy:

"Care will be taken that the income of health workers will not, in anyway, depend on the type and quantity of medication prescribed." This policy is to be applauded provided that it does not undermine the quality of care.

With regard to the "one exit price policy" it must be stated that multinational drug companies are involved in sponsoring research, CME programmes and other community upliftment programmes.

While we agree that drugs in general are overpriced, we feel that a degree of caution should be exercised in dealing with this matter so that this important resource is not lost to us altogether.

The right to dispense medicines should continue to reside with the GP and is essential to providing health care in underdoctored areas. If this facility is removed, health services are sure to break down even further. This service is also valued by the patient. While we agree that certain controls with regard to dispensing of medicine have to be instituted, we would urge you not to throw the baby out with the bathwater.

(2) Others:

Mention is also made of the "management of chronic illnesses, promotion of healthy lifestyles, programmes for the early detection and cost effective management of chronic diseases and cancer, control of communicable diseases, family needs, mental health, rural health, research and maternal and child health". From the above it is clear that there is a tendency to fragment healthcare even further on the basis of specific categories. We believe that the provision of separate facilities bring about a duplication of services on the PHC level which is not cost effective. The State could and should deploy its resources far more effectively by utilising the professionals to provide an integrated, comprehensive health care service on the primary contact level. The vocationally trained GP is in an ideal position to cater for all of the above needs.

We would strongly suggest that the matter of Rural Health be seriously addressed for example by a National Strategy for Rural Health for example by:

- Initiating an underserviced area programme with clearly spelt out incentives or legislation for retaining health workers and encouraging career options.

- Including non-health issues such as schooling and job opportunities.

D. The NHS

At present we have a problem with some Community Health Committees in that there is no

doctor representation. We firmly believe that in the interest of democracy (and also basic logic) that doctors should be involved when it comes to planning community health facilities. Community health workers are to receive ongoing training and the Academy can certainly assist in this regard.

It is also stated that "all community level services, both public and private, will fall under the DHA from which they will receive substantial material and logistic support". We would like to know how the independent practitioner would fit into this model. One possible suggestion is to mobilise selected existing practices as "group practices" consisting of doctors, nurses, social workers and other health workers under one roof such as is the case under the NHS in the UK.

We want to express our support for the concept of an NHS (with an independent /private practitioner component) if it is organised efficiently and leads to an improvement in the present levels of service.

E. Role of the Private Sector

The following points emerged from the document:

(1) Independent GPs will fill an important role in PHC and must be integrated into the broader, comprehensive system. The majority of independent practitioners will become an integral part of the NHS but maintaining their independence.

(2) Private practitioners will be encouraged to work in public clinics, health centres and hospitals.

(3) Tax concessions for medical aid contributions to be reviewed.

(4) Peer review, audit and agreed protocols.

(5) Continued support for NGOs which respond to expressed needs at community level.

(6) A National Registration Board, charged with accreditation of educational programmes and awarding legal entitlement to practice.

(7) Annual re-registration of all personnel will be subject to continuous education programme participation.

There are some good principles amongst the above but the stated aim is to reduce the private sector. We feel that the private sector will still have an important role to play in a new dispensation. It should be remembered that the "Private sector" and Public sector represent a massive existing resource which has cost the country and its tax payers untold fortunes to train. It would be a tragic waste to allow this pool of potential assistance to PHC to go to waste. Rather, should we be looking for the best ways to integrate and harness the private practitioner into the health care system so that he/she can become an asset and not a liability. Here the Academy would be only too willing to offer its assistance.

The public sector can learn quite a lot from the private practitioner with regard to the dignified and cost-effective treatment of patients, with continuity of care, and this information should be utilised in your forward planning.

We feel that there are no significant differences between generalists employed in public facilities and those in private practice – we are all Family Physicians and are all striving to achieve the same objectives. We see ourselves as filling an "Expanded Role" in a new Health Care dispensation. We are of the opinion that it would be acceptable that public healthcare responsibilities are contracted out by the State to these "expanded role" practitioners. The exact way in which this would be done to ensure an equitable distribution of work, would have to be a matter for negotiation between the State and the appropriate medical representative body. The advantages which a Family Physician service provides are:

1. Community based care
2. Accessibility
3. Personalised care
4. Continuity of care
5. Comprehensive care
6. Accountability

These are all features which are now been sought in a "new" Health Care System. The role of the FP should not be seen in isolation in our country but also in relation to the Health Care Systems of the region of the world.

An integrated, non-fragmented "one-stop" approach should be adopted by PHC service points. Continuity of care should be encouraged at all times. This will engender mutual trust and better patient compliance. Continuity of care refers to a commitment to care for the individual, family and community over time. This implies commitment to health and to the individual and community prior to development of disease or illness.

PHC services should be supported by successive levels of referral facilities. This implies that a strategy should be supported by a need to review the functions, staffing, planning, design, equipment, organisation and management of secondary and tertiary health centres and hospitals to meet the needs of the primary sector.

We also note that "the provision of private health care will continue to be acknowledged and regulated". We would like to know the nature of this regulation and the potential benefits to the patient.

Have actively practising GPs in planning so that compassion is never lost to administrative mandarins

The health document also states that the State will accept financial responsibility for CME but we would like to see the State go one step further and follow the Australian Government's example of backing a vocational training programme for family practitioners. The Academy has the resources (regional and national) to assist significantly in this regard and we would like to be involved at all levels, including rural programmes.

F. Management and support system

1. Innovative ways of utilising secondary and tertiary hospitals:

   We suggest – Direct access by GPs

2. Licensing of new practitioners:

   We ask the question: – Should there be a limit to the number of practitioners and Private Clinics in an area? This could be one way of redressing the maldistribution of health personnel.

3. Compassionate and efficient management:

   The private sector already does this very effectively. It is stated that you will introduce management practices that are aimed at efficient and compassionate health care delivery. However, large organisations and compassion are not cosy bedfellows and we would suggest that you always have actively practising GPs represented on these planning structures so that this facet of compassion is never lost to administrative mandarins who see only statistics and not the individual.

G. Human resources development

1. Personnel education

We would suggest that this issue be looked at (in all job categories) specifically with respect to:

- Pre-employment training
- Development of communication and interpersonal skills.

2. Staff development and CME

In the ANC Health Document, CME is seen to be the financial responsibility of the NHS and would be implemented through tertiary educational institutions. It must be ensured that the programmes are:

- Addressing both urban and rural needs
- Community based and orientated
- Run by appropriately trained family practitioners
- Geared to the development of rural education centres.

The State presently trains specialists for the private

sector but does not contribute significantly to the training of Family practitioners. We would recommend that the State puts more of its resources into the training of Family practitioners.

To promote the concept of accountability, we would encourage staff participation and involvement in decision-making.

3. Democratic and Representative Statutory Professional bodies

- Must accept the principles and philosophy of a PHC approach
- Need to be made more representative in keeping with the demography of the country.

The impression is gained that the ANC document has been drawn up without significant input by practising clinicians, especially Family Practitioners. To ensure that the new system is balanced, we suggest that all organisations representing health personnel and other interested parties, truly representing their areas of expertise, be consulted on an ongoing basis.

This analysis represents your National Council's draft response to the ANC's Health Document. However, we regard the re-organisation of the Health Services as an issue for ongoing debate and we would welcome any input from individual members (or small groups in the South African Academy of Family Practice) by communicating with your Regional chairman or writing to The South African Family Practice Journal.

Family Medicine and the ANC's Draft Health Plan

The ANC's draft health plan is a well elaborated statement of intent which addresses the major deficiencies in health care in South Africa now. In my opinion it has shortcomings which will limit its applicability in the development of a new health care system. The drafters have borrowed too freely from the World Health Organisation's generic Primary Health Care approach without acknowledging the complexity and variable depth of our existing services. They have assumed a straightforward transformation of our system without proper consideration of what such major realignments will actually entail; and finally, they have omitted the contribution that family medicine should make to our health services in future.

The Family

The biggest omission concerns the provision of essential personal health services; virtually no mention is made of the place of the family in health, sickness, disease and health care overall except in relation to the declaration of Alma Ata and to family violence – although reference is made to individual and family health in the organograms depicting the structure of the planned service. While great emphasis is rightly placed on the health needs of particularly vulnerable groups such as women and children, the family itself is ignored as though the harm done to family life in South Africa where not one of apartheid's most abysmal legacies of damage.

By leaving family medicine out of the plan the drafters have omitted a key component of any modern state's system of health care, even a state with as grievous a history of deprivation and neglect as South Africa.

The family medicine approach, embodying the principles of: continuity, co-ordination, community, comprehensiveness, prevention and family, could help the health planners realise their aims in spheres such as: disease prevention, lifestyle change, health promotion, and the management of chronic disease.

We should not allow the negative view often taken of the private general practitioner in South Africa's fee-for-service system to obscure the country's need for a service based on the principles of family medicine. The responsible family physician, as part of a team and in either the private or the public sector, will have a key part to play in the delivery of essential personal health services in South Africa in future.

Family Medicine

We must harness the resources of the private sector so as to serve the need of all South Africans for a health service capable of serving them equitably and equitably rewarding those who provide the services. A national health insurance plan based on a capitation system of payment would help us to meet the future ministry's aims in health care.

It is too simplistic to pretend that the health needs of South Africans could be easily reduced by preventive programmes although conditions like measles for instance that can be prevented must be prevented. Sound family medicine can be a vehicle for such preventive services; not for just a privileged few but for all those in need of care.

Oversimplified reference is made to the changing of lifestyles and the management of chronic disease without any recognition that these are vast and costly undertakings that have challenged the capacities of countries with much better established systems of health care. Issues such as lifestyle change and health promotion are the very stuff of family medicine – family medicines has much to offer South Africa in its pursuit of an accessible, equitable and affordable health service.

If we fail to incorporate family medicine's strengths into our health care system now we will undergo an uncomfortable decade of change only to learn at the end that we still need family medicine. We will then be in the invidious position of needing to fit the ethos of family medicine into a system not designed to accommodate it. Family medicine must now take it's rightful place in the formation of a health service which will serve all South Africans and which all can take a justifiable pride.

The 'space' that family medicine can offer someone seeking help may be the only private caring space available to an individual South African whether they come from a shack or a mansion. The joys and the woes of the individual in the family respect no boundaries of colour, class, or wealth; they are an ever-present reality for us all. It is therefore imperative that we include family medicine's strengths in our National Health plan to ensure that we develop a Health Service capable of offering a compassionate human face in response to an inescapable human need.

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* Based on comment offered to the ANC Health Department in response to their January 1994 draft document – A National Health Plan for South Africa