Forum

SA Family Practice as the mouthpiece of the SA Academy of Family Practice/Primary Care, is primarily interested in raising academic standards. Standards of medical practice depend on the quality of the people in the profession and the standard of the training they have received. Secondary to this, but not unimportant, is the influence the health care policy and system has on academic standards. The Academy is also interested in helping to make primary care of high standard available and accessible to all people. South Africa is not making good progress towards this aim at present, so we are glad to place Dr Ingle's letter in the hope that it will raise much discussion and real action.

Babes in the wood

Letter to a colleague

Dear Sam,

Is it ten years since we sat up till the small hours talking about health care and the medical profession? You said in your letter "when shall we do it again?" I wonder; but as things are I've decided to write instead. By then our outlook had changed radically since we began medicine. Our devotion to good clinical practice had actually strengthened but we had discovered we owed more than that to our constituency, the community out there — "the faces outside pressed against the glass".

> "Recently Stewart denounced 'the glass curtain round the little tight world of medicine. On the inside of the curtain is the glaring antiseptic world of medical exellence, its wonders plainly visible to those outside. But the curtain seems to be made of one-way glass. Those outside could see in but those inside seemed to scarcely notice the faces outside pressed against the glass.' "
>
> — Stewart WH. Perspect Biol Med 1967; 10: 462. Quoted by Justus. Bantu Medical Education. *S Afr Med J* 1967; 41: 1203.

From our reading we knew this personal revelation was being shared world-wide. Immersed in disease indeed we were, but we could admit our professional preoccupation with it. The ideal of health as the goal of our health service activities is strangely new — health as a measure of the quality of personal existence in terms of personal and cultural values. People are not objects for care posing technical problems, but personalities with personal problems, to be party to decisions about their health.[1] And the point of care shifts towards people where they are, in both a physical and a cultural sense, so as to be accessible and acceptable. The social and physical environment they live in, often not of their free choice, are major determinants of their health. Others are the role the State adopts, the kind of doctors we train, the direction the mighty power of medical research pursues and, in short, the way we use our very finite resources.

So we said we didn't need any more message; its literature had proliferated enormously. The problem was how to act on the message, how to "get the show on the road". I quoted Professor Brock addressing the UCT Medical History Club in '75: "In the smokescreen nobody can see what is happening, much less is the problem tackled", and calling for a consensus between all the branches of the medical profession.[2]

You say a lot has happened since we talked and I agree. What shall we mention? A new Health Act in 1977? (How many doctors know the difference?) New governments and new Health Departments? (Interesting how concerned people get about rural health services now that they're run by other governments!) The Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care? (Everybody happy about the extended role of the nurse?) Vocational training for GPs opening up? (And new styles of conferences too). A new wave of medical students with understanding of community medicine? (Even pushing their teachers for curriculum revision!) The 1978 Conference on the Economics of Health Care in Southern Africa?

Yes. A lot has happened. But how much has changed? At that conference (it was not long before his death) Bernard Pimstone gave the opening address and said:

> "I have often been conscious of the necessity for a wide overview of the health needs of Southern Africa as well as a forum of involved persons, from State Health officials to medical practitioners, economists and sociologists to meet and cogitate over these issues and consider some kind of blueprint from which manpower and technology, combined with attention to changing social patterns might help to create an acceptable medical care programme for all South Africans — urban and rural. The scope is formidable."[3]

Then last year Solly Benetar, in the *S Afr Med J*, reviewed "the message" and said:

> "Medicine in South Africa is at the crossroads. The future of academic medicine and of our overall health service has not been adequately defined. Both are endangered by inadequate support in the face of population growth. Moreover, there does not appear to be a forward-looking national health policy with

> adequate financial backing to prevent this. The public and the medical profession should be aware of these short-comings and should contribute both to formulating a solution and to its implementation."[4]

Here we have repeated cries for action. But the language used for turning concepts into solutions and programmes is uncertain. What does Pimstone really mean by a forum of involved persons? How do State Health Officials meet and cogitate with medical practitioners? (Can the lion lie down with the lamb!) How can the public and the medical profession contribute to a national health policy?

In general the medical profession feels frustrated or, worse, cynical because it poorly understands the structures and processes for planning changes and making decisions. The key to action is access to the planning process. This is what I have been discovering since we talked.

THE PLANNING PROCESS

Let me recap the essentials of that process. It has to start with a policy which, in this context, expresses goals or objectives for health promotion and, in broad terms, how they are to be achieved. Those strategies will determine specific programmes, from which you proceed to the resources required. Now the ***relevance*** of such planning depends on using people in touch with the realities of the situation and, if available, good data about it. The ***feasability*** depends on positive and negative factors at every stage, ranging from the socio-political to the topographic, and on resources available. Evaluation of such constraints is part of the process and results in modification at every stage.

These essentials underlie effective activity in any sphere of life, and are applied in many. They apply to planning on any scale, be it a national health policy, the restructuring of services or a programme against a specific disease. They apply to ***planning the planning process itself. Participation*** has to be planned. It may be multidisciplinary, multisectoral, from different levels of responsibility and from various interest groups. ***Expertise*** is needed. Here the clinician has to recognise that other kinds of professional expertise — economic, administrative and political — are also necessary. The process will experience tensions, not only between goals and resources (which it exists to handle), but also between participants who have their different frames of reference[5]. Snaith compares the planning ethic with the quasi-market ethic of clinicians who compete with one another in a medical market place. Thus the health policies that are implemented have emerged from a competitive process.[6]

So we can say that ***experience*** of the process itself is also important. And the process takes ***time,*** time to take off and time to keep going.

But above all, I would say, the process has to be ***authentic.*** I mean that, in the way it is initiated, in the way it is structured and in the way its deliberations are used, it has to have an explicit relationship — it has to "plug in" — to the decision-making of its parent body, in this case, government. Many stories can be told of planning that failed and commissions shelved for lack of authentication. How instructive post-mortems could be! (What happened to Gluckmann anyhow?)

FREE MARKET VERSUS SOCIALISATION

I think our profession has not only to recognise that it is pretty short on expertise and experience in the planning process, but that it has major hang-ups regarding public health care. One is that socialisation of medical services is a recipe for disaster.

Admittedly Professor de Klerk's opinion that the British National Health Service (NHS) is an example of satanic inspiration ("uit die bose") is extreme![7] But, as Archer says, 'a general presumption in favour of market allocation mechanisms is prevalent in South Africa'.[8] The free market system is quite commonly believed to respond sensitively and efficiently to need. But medical services have peculiarities which preclude allocation via supply and demand forces,[8] and, as Nattrass points out, the market system results in ***compromises*** due to its shortcomings as a decision-making process.[9]

Further, there is cold comfort for those whose ideal is the free and independant practice of medicine financed through the market for private services on a fee basis. Archer quotes Professor Abel-Smith's finding in the USA that combining free market medicine with health insurance results in interference greater than when physicians are salaried government employees![8] Socialisation is a word being used to conjure a Pandora's box of untold evils. In health service planning it means the method of financing health care in which there is public funding of a comprehensive health service. Like any economic system this has its own share of pitfalls. As for the spectre of socialisation, just note that the percentage of the gross national product spent on health services by the government is actually ***decreasing!***[10,4]

But the main achievement of "the socialisers" was to set and pursue objectives for health care in a way that had never been done before. No less an eminent clinician and BMA administrator than Walpole Lewin, the neurosurgeon, wrote that "whatever its faults, few would deny that the NHS was a major social and humanitarian contribution to society which has benefited millions of people of which we can justly be proud".[11].

I'd say doctors are being lead to prejudge these difficult issues by little short of soap-box oratory. Perceptive analyses by authors such as I have quoted show that for the profession to polarise freemarket and socialised financing of health care in black and white terms is simplistic indeed.

CLINICAL AUTONOMY AND RESOURCE ALLOCATION

The profession is probably less hung-up about limitation of prescription as a threat to clinical freedom than it was, now that it recognises that over-prescribing, cost escalation and, for example, antibiotic abuse, should be curbed. It is the subject of WMA's Eleventh Principle of provision of health care in any National Health System:

> "In the highest interest of the patient there should be no restriction of the physician's right to prescribe drugs or any other treatment deemed appropriate by current medical standards."

Of course it depends what you mean by current medical standards. But there are those whose attitude is that there should be no restriction, fullstop! Or who equate current medical standards with the best in the world, especially when spending public funds.

But the profession's concern about resource allocation is really far wider than "drugs and other forms of treatment". Walpole Lewin predicted that if a doctor is to ***retain*** his independence he must take part in determining priorities so long as resources are limited.[11] The Deputy Director-General of WHO, Dr Lambo, thought the individual prescriber had a clear responsibility because it was his judgement that determined the use of health resources.[12]

So, do we opt to be inside the movement for planned health care and play our part in the process, or stand outside it? (And criticise!) The position of the WMA, at least seems clear! The preamble to the Twelve Principles says:

> "(WMA) has a basic duty to safeguard the basic principles of medical practice and defence of the freedom of the medical profession. In consequence (my italics follow) ***it***

> ***cannot be expected to produce value judgements on the different systems (of national health care)*** but has an overwhelming duty to decide as far as possible upon what terms the medical profession can collaborate with State Health Services."

I think much of this posturing can be traced to an unfortunate presumption that autonomy, if not a divine right, is inherent in professionalism. I know you have already seen McIntyre and Poppers' *Br Med J* article.[13] But listen what Elliot Freidson has to say:

> "(Professionalism) defines the work to be extraordinarily complex and non-routine, requiring for its adequate performance extensive training, great intelligence and skill, and highly complex judgement that cannot be evaluated by any straightforward and definite rules. The truth of that definition of work is, though not really established empirically, generally accepted by professional writers on the professions. Its truth is, however, irrelevant to understanding the important role it plays in professionalism and in the struggle to gain or maintain professional authority, autonomy, and prestige. ***Belief*** in the extraordinary character of the work and of the performer sustains the worker's claim that he must be able to exercise his own complex, individual judgement independently of others, that is, he must be independent and autonomous. While members of ***most*** occupations seek to be free to control the level and direction of their work efforts, it is distinct to professionalism to assert such freedom is a necessary condition for the proper performance of work. And it is precisely such an emphasis on individual judgement and independence, founded on a conception of the character of the work, which allows the self-regulatory process of the professions to shift from the ideal of responsibility for the actions of one's colleagues to concrete responsibility for oneself, to shift from belief in the ideal of responsibility for the public good to the practice of responsibility for the good of one's own personal clientele."[14]

BUREAUCRACY AND PROFESSIONALSIM

Quoting Freidson on autonomy leads me directly to another hang-up, namely bureaucracy, which the profession loves to hate! This antagonism is ironic in the light of Freidson's piercing analysis which you must read. He says the professional's performance "can produce the same barriers to communication . . . the same structure of evasion, and the same reduction of the client to an object, which have been attributed to the bureaucratic organisation . . . But unlike bureaucratic practices, which in rational-legal orders are considered arbitrary and subject to appeal and modification, professional practices are imputed to have the unquestioned objectivity of expertise and scientific truth, and so are not routinely subject to . . . outside appeal".[14]

Irony apart, the issue he sees arising from an autonomy which he regards as pathological, is that "who is to determine what the goals of the service are and the concrete modes by which its goals are to be pursued."

THE MEDICAL ASSOCIATION OF SOUTH AFRICA

What is the stance of MASA on some of these issues? I find the pronouncements — in News from the Secretariat, *S Afr Med J* or in *SA Medical News*, which quotes the Chairman of Federal Council extensively — full of ambiguities, which seem to get worse the more I study them!

Its opposition to socialised systems of medical care, from which it considers nowhere in the world has the public benefited, is very clear.[15] Yet it can still say that "it is the duty of the government to promote the health of the people even if it should require unpopular measures. For the deciding factor should never be whether the patient 'considers it as good or poor services' but whether it is in fact in the best interests of the people. Were it left to the people . . . a chaotic situation might arise".[16]

It considers that health is a primary responsibility of every individual, but recognises that more than 50% of the total population cannot exercise that responsibility.[17] For these the State is responsible and this system is "an ideal mix".[15]

It believes medicine should not support or reject political ideals or policies but recognises that political patterns and philosophies have profound influences on health policies and standards of care.[18] It seems as if MASA is party to the silent concensus of white society that "politics" is about racial issues and as such is a "no-go area". Other countries accept that politics includes the full range of matters affecting the welfare of society and that interest groups have to do battle in that arena as a fact of life. In fact, MASA's agenda of negotiations in recent years reflects a variety of political issues that it has, in some instances with pride, involved itself with. It is at present extremely concerned about the fragmentation of health care amongst the various sovereign and self-governing states of Southern Africa.[17] The result of its stance is an inability to confront issues of health care squarely. This is why the National Medical and Dental Association, which sees national health as a political matter, parted ways with MASA.

MASA is often consoling itself with "the high standard of medicine in South Africa".[18,19] MASA is understandably determined to lionise the abilities, skills, diligence and humanity of several generations of South African clinicians. So am I. But this ought not to be confused with standards of health care, the objective measurements of the health status of the nation or the outcomes of its health care system. And that, I am afraid, is a totally different story. What's more many of these measurements do not exist or are relatively crude. Indeed health service research — practised in the much maligned NHS by the way! — is minimal. There are very few people doing it, or capable of doing it.[20]

CURRENT PLANNING

One of the "funnies" you see on office desks says "One possible reason why things are not going according to plan is that there is no plan". If there are rumbles of discontent and cries go up for a forward-looking national health policy, does it mean there is no plan? Or does it mean we don't know about the plan? An opinion poll of the profession would be interesting.

QUESTION: How is health policy on a national scale being determined? Name any council, commission or foundation charged with the task.

Answers should include the following:

1. *National Health Policy Council*

> "The purpose of the Health Act is to create legislation, a blueprint for rendering of health services by the three tiers of government. Provision is made for . . . determination of health policy on a national basis . . . to utilise the available resources to the maximum, and in so doing to render the most effective health service to the population of South Africa."
>
> Guide to the Health Act 1977 (No. 63 of 1977)

In terms of the Act the Minister of Health and Welfare is advised by a Health Matters Advisory Committee which is assisted by expert Subcommittees of which there have been nineteen. He is Chairman of the National Health Policy Council, which adopted in 1980 the National Health Services Facility Plan designed by the Advisory Committee.

Incidentally it was this Plan that Dr Howard Botha referred to in an important letter in the *S Afr Med J* written on behalf of the Department of Health and Welfare. He disarmingly enquired whether MASA could be relied upon for support in

the future when the Plan became the target for vindictive politically inspired attacks.[21]

2. *Browne Commission*
The chairman, GWG Browne, and eleven members were appointed by the State President in 1980 to make recommendations on the range and cost structure of health services in the public and private sectors in the Republic with a view to the rationalising of services, the promotion of more effective services and the placing of the costs of services on a sound and firm basis. As far as I know it has published no progress reports, which is not surprising under the circumstances.

3. *Health Foundation of Southern Africa*
I mention this because its establishment, as "important" for the planning of future health programmes," was envisaged by MASA as a result of "in-depth research" and announced in *SA Medical News* in 1982.[17] I have seen nothing since, but mention it, nevertheless.

That, of course, is one of the problems — communication! It is always irritating for management when it has a plan but people on the floor know nothing about it. I know the feeling well! The Department of Health and Welfare and the profession would probably differ in their perceptions of the amount of publicity given to the existence of the provisions I have mentioned. Nevertheless my guess is that the profession is largely unaware of them. And, is that not understandable if the NHPC and the Browne Commission, once established, are forgotten because progress, for whatever reasons, is not publicised?

I mention such current planning as a measure of the profession's unawareness, not to say that the future is taken care of; and certainly not to defend the quality of the planning which I am not in a good position to judge. I have said that planning health services is a sophisticated exercise, in human as well as technical terms. However "participatory" the Advisory Subcommittee system may be, there is still a great shortage of planning personnel engaged in such exercises. It adds up to saying that the whole approach of the profession, and of MASA its mouthpiece in particular, is rather like tackling Everest in tackes and T-shirts.
Since I began this letter Julian Tudor Hart's remarkable and inspirational Pay Byrne Memorial Lecture has appeared in the *Br Med J.*[22] It deals with British health service policy, particularly from the point of view of the general practitioner. It really should be compulsory reading for us all.

> "It is true that the public health tradition, here as in most other countries, has been impoverished by its divorce from clinical medicine, a divorce for the most part imposed by the profession itself. Under any circumstances community medicine will take time to recover from a century of banishment to the periphery of medical practice, but clinicians will also take time to recover from their ignorance of the tasks of organisation, management, local planning and research based clinical strategy."[22]

You can be in no doubt that I am in favour of "socialised" objectives and admire the achievements of the British NHS. When we realise the shape, direction, experience and achievement that that service already has under its belt, then I think we are little more than babes in the wood,

You in your nek of them and me in mine!

Yours ever,
Ronald

PS. The views expressed are my personal views.

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5241