From the Editor

It is generally accepted that a little more than 50% of South Africa's doctors work for the public sector. We do not know how many of these are in Primary Care. Van Selm shows elsewhere in this Journal that there are many patients of little means who avoid the public sector primary care service and go to a private practitioner.

The SA Academy of Family Practice/Primary Care has the view that the principles of Family Practice — which some people want us to apply only to the private sector — are applicable to all forms of primary care. This includes the public sector primary care which consists of varied forms of practice, such as General Outpatients departments, clinics of various kinds, manned either by nurses, or nurses and doctors, and rural comprehensive health care schemes which are usually structured around a small hospital.

Inbetween the traditional public and private sector there still are various forms of salaried doctors, such as those employed by large corporations, as the Mine Benefits Fund.

McWhinney[1] argues that the world-wide resurgence of Family Practice is in response to a very deep-felt community need for reinstating the patient as a person. To enable this to happen, some principles of practice have become quite clear. Primary care should be practised in a situation where there is an ongoing personal relationship between the health care deliverer and the patient over many years. This care should be as comprehensive as possible and the patient should be able to bring any problem of health or disease to the primary health care worker. Care should therefore be personal and continuing — with no passing of the buck.

It seems that many colleagues are quick to ridicule the National Health Service in the UK. These same people sometimes accept full time salaried posts in our government primary care sector. Outside the homelands with their comprehensive health care systems centered around small district hospitals the primary care available in the rest of the RSA public sector is probably amongst the worst of the systems available in the world today.

In our cities, primary care is often divided, between three authorities, the city council, the provincial council and the State Health Department. Our public sector care is mostly impersonal. Patients enter large buildings with long queues and long waits. People attending seldom relate to one health worker but see different staff members at different times and days and for differing conditions. This massification and division of primary care is not only impersonal but often results in polypharmacy, unnecessary frequent consultations and bad clinical management of problems as well. It favours the "nobody-has-responsibility-for-the-patient" syndrome.

If we do have to have public sector primary health care for more than half the doctors and the largest portion of our population, then let's rather have the NHS from the UK! Unlike their consultant colleagues, the British general practitioners are not salaried but independent contractors to the state for the delivery of primary health care to the people insured by the state. Their primary loyalty is to their patients for whom they have to compete with other general practitioners and not to the one who pays their 'salary'. They have a comprehensive 24 hour contract with individual people to whom they deliver a personal service.

A primary health care service that is not personal, continuing and comprehensive will in today's world eventually be rejected by our patients. Many already pay a high price to get away from 'factory assembly line' impersonal care.

Reference

1. McWhinney, I R. 1981, *An introduction to family medicine.* Oxford University Press, New York.