Health Care and Justice

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SUMMARY

Some thoughts about the concept of adequate health care delivery to all the people in a community are discussed. This is done briefly in relation to resources, the structures within which this care is delivered, and in relation to medical education.

S. Afr. Med. J., **48**, 2339 (1974).

Concepts of health care delivery are continually changing and developing. Medicine has passed through a phase of being purely a 'scientific' discipline, towards realising the importance of the psychosomatic. From about 1965 a new awareness of the social dimension and the total ecological situation[1] has also been added.

This new awareness has stimulated people to think in terms of providing adequate health care for entire populations. It seems that more than half of the world's population has no access at all to health care as we practise it, and many of those who do get it, get care which does not answer their problems. This thinking has stimulated Bryant to say: 'Every apparent medical success must be measured against the needs of all.'[2] When the use of resources is evaluated it becomes uncomfortably clear that lives are lost and crippled in some places, while life-saving resources are wasted on trivia in others.

Throughout the world the economics of health care are also making people reconsider their systems of health care delivery. McNerney says that in the USA 'there is widespread concern about health care costs and poor access to care, particularly among low-income groups.'[3]

Health care seldom enjoys a high priority in any national budget, and therefore both the affluent and the poor countries of the world find money to be a severely limiting factor. No country is able to sustain unchecked increases in the funds allocated to the treatment of illness; and more and more people are being forced to face the fact of limited resources and the need for priorities.

In most countries, however, serious inadequacies in the health service reflect not only poverty of resources, but also the structures within which this service is delivered and the education of health personnel.[4] Some of the worst deficiencies are caused by structures that match neither needs nor resources, and by educating health personnel to have limited relevance to the work that needs to be done.[5]

It has been shown that the emphasis of providing good hospitalisation as the basic structure of health care in most African countries has limited the availability of the services to 20% of their populations. This is by virtue of distances to hospitals and the money involved in maintaining them. Hospitalisation is expensive and mainly curative, and thus deprives 80% of the people of any service whatsoever.[6]

Irrelevant teaching is well illustrated by teachers from Europe who spent much time teaching students in equatorial Africa to treat frostbite!

Whether it is budgeting, planning and control of service, or teaching that we are involved in, we are in each case involved in priority decisions. Decisions which make services available to some, and deprive others. Many of these decisions are made easily and in a detached way by politicians and medical and other administrators. Some are made by teaching faculties and others are made at the level of the clinician faced with the patients.

It is at this last level that the decision is difficult. One Transkeian doctor at times has responsibility for total health care for 50 000 people. Does he provide something for all, or does he only care for those who come to him? Can he leave an acute abdomen to sort itself out while he tries to control tuberculosis or measles in the community as a whole? We have found most doctors unwilling to face these issues and make priority decisions purposefully. Most of us prefer to tackle each problem as it comes. We keep ourselves too busy to step back and look objectively at our work and all the people for whom we are responsible in a comprehensive health service in order to make priority decisions.

PRIORITY DECISIONS

Indirectly, however, all of us make decisions, even if it is by default.

We congregate in certain areas where medical practice is enjoyable and lucrative. This congregation of medical personnel also draws with it better facilities which cost more. Disproportionate spending of money per population in different areas follows and causes further clumping of medical personnel, until they clot up all the passages in the ivory palaces of disease.

We set standards which send us in directions which deprive many of care. This is happening where we confuse greater technology with improved health care, causing excessive specialisation. We find ourselves preoccupied with input in terms of man-hours and standard of technology, rather than with results in terms of improved health. Many are today concerned with our tendency for professional self-indulgence. Maldistribution and excessive specialisation are the most acute symptoms of this disease among ourselves. The net effect is that many who could possibly have received the basic minimum of health care (if there is such a thing!) are totally deprived of all care.

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WHAT CAN WE DO IN SOUTH AFRICA?

Assuming that it is right that we should provide adequate health care to all people, what can we do to accomplish this in South Africa?

Philosophy and Structure of Work

Although we have the theoretical framework of the comprehensive health service as our ideal structure in the homelands, this has not been put into practice on a large scale as yet. Our thinking is still in terms of providing a good hospital service, and not of providing adequate health care to all. We have heard it said that preventive services are cheaper and more effective in terms of health benefit to a community than curative hospital services. How many doctors as yet have left the one for the other? How many have made a priority decision in terms of costing lives and improved health benefit?

Training and Aspirations of Medical Personnel

In our training as medical students we are introduced to the best facilities. We are urged to have the highest standards. This is, however, only possible in a medical school which also has a very large share of the budget. Groote Schuur Hospital spends more than twice the amount of money in one year on maintenance costs than the Transkei on its total health vote for its population of almost 2 million people.[7] It thus becomes very difficult for this school to produce doctors who will aspire to and be able to practise the kind of medicine which is possible within the limitations of the Transkeian budget. The problem increases if this money is to be used in a service for all and not just for the few who may be privileged to gain access to an institution attempting to reproduce the medicine learnt at medical school.

Medical schools must become more aware of this discrepancy and give the problem some serious thought. It seems as if the net result of present training is an increase in our maldistribution. There are many who feel that training for a particular task should be done as close to it as possible in terms of medical environment, and also geographically, so as not to lure people away from where they are most needed. Training should already make students aware that they will have to cost lives and set priorities. There is no bottomless pit to provide the maximum facilities of medical technology to all people.

In South Africa training should include a big slice of learning to increase understanding of cross-cultural communication, for both Black and White medical staff to understand that what is applicable to one community does not necessarily apply to the other. Ignorance at this level of practice has many toxic effects in the community and costs the country much in paying for ineffective and sometimes harmful work. When we practice Western scientific medicine in an African community, we are handling a very strong secularising force in that community.

Our medicine thus perhaps has a more profound influence than if it were practised only intraculturally. Training must therefore also give students an awareness that medicine is both part of the solution and a cause in the whole ecological dilemma.

More Realistic Distribution of Funds

We have only to look at the statistics in the latest *Hospital and Nursing Yearbook of Southern Africa* to see the great disparity in maintenance expenditure. This is even greater if one includes capital grants for providing extensions to the service. However we look at it, it is unlikely to change radically towards a more even distribution. Any homeland spending more on health would thereby become more dependent on external grants. On the other hand, we are all together in one country and should see that each person gets an adequate amount of health care. This is a basic dilemma and tension in our country which we all have to face and work upon in all spheres of life. Whatever hope there is in the future for a more even distribution, we have to face the present situation in the Transkei, with its very limited resources being utilised by medical personnel trained in affluent Western circumstances, who largely wish to reproduce those circumstances they know to be 'best'.

CONCLUSION

We do not want a second-class service or second-class doctors. We wish the best possible for all. I think the consensus at present is that this can only be achieved by redeploying nurses in a new role, which in many ways is similar, though not identical to that of the medical auxiliaries employed in other countries. We cannot pay for nor train enough doctors to give medical care directly to all people. The changed role of the nurse needs a new doctor who is to lead, teach and delegate.

We do want and need an adequate hospital service but it should not become our ultimate aim. We must think in terms of health care and promotion for all and concentrate on less expensive and probably more effective work such as health education and preventive medicine. This also needs a new doctor — which is difficult to produce in our institutions of learning dominated by advanced technology and curative medicine.

This position has been well stated by the Secretary for Health, Dr J. de Beer, when he challenged medical students to enter new fields and improve the future by participating in those areas which offer most room for improvement.[8]

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