THE MEDICAL PROFESSION IN THE SERVICE OF SOUTH AFRICA'S PRODUCTIVE ENTERPRISE*

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In the early days of the Industrial Revolution, the Industrialist is reputed to have cared little for the welfare of his employees. Today, however, he has a highly developed social conscience and is, in any case, forced by the general shortage of labour and the high cost of training to take an interest in the health and welfare of his employees. Nowadays, even if labour were in free supply, the employer must face the cost of training each replacement to the high degree of speed, efficiency and skill required in this competitive world. Problems of absenteeism and labour turnover, aggravated by the labour shortage and specialised skills, have become of the most major importance to the very existence of a producing concern.

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TABLE I. GROWTH OF THE INDUSTRIAL POPULATION

Year	*Number of Workers*		*Index Base:* 1924—100	
	White	*Non-White*	*White*	*Non-White*
1924	53,450	99,297	100·0	100·0
1932	68,981	95,809	129·0	95·5
1939	115,292	199,196	215·7	200·6
1944	133,518	297,884	249·8	299·9
1949	191,291	426,888	357·9	429·9
1952	217,447	523,865	406·8	527·6

Table I illustrates the increase in the number of industrial employees during the 28 years preceding 1952. This increase has continued during the past 5 years and the shortage of labour, particularly of skilled labour, continues to be chronic.

ANALYSIS OF MEDICAL SERVICES TO INDUSTRY

Analysed from the administrative/financial angle there are, generally speaking, 3 main types of medical schemes in the service of industry:

1. *Factory Medical Care*

Provision of first aid facilities at the works has been required since the earliest industrial legislation was introduced. Today larger firms have developed these first-aid facilities to a stage where a full-time nurse is employed and the services of a part-time doctor are retained to provide a reasonably comprehensive 'curative' service. The part-time doctor not only attends to accident injuries but also to minor illnesses. Employees can therefore have their minor ailments treated at work and so avoid having to take time off and lose pay to go and visit a doctor. Large concerns in the country districts or in smaller centres have gone so far as to erect a sick bay or small hospital with a nursing staff and perhaps a full-time doctor.

A more recent development has been the provision of a factory medical service run on 'preventive' rather than on 'curative' lines. From the point of view of efficient production, the employer is concerned with the promotion and maintenance of the fitness and health of his employees. Except to achieve a speedy return to work and from a general welfare point of view, productive efficiency is not affected by the arrangements made for the medical care of employees who are absent because of illness. The 'preventive' service therefore aims at maintaining a continuing interest in the employees' health and welfare in an attempt to foresee and avoid illness and sick absenteeism and to promote the employees' efficiency and happiness in his work. This introduces a number of new factors into the field of the factory medical service. A man's attitude to, and efficiency at, his work is influenced by the health of his family as well as by his own health, and psychological aspects are almost as important as the potential spread of disease. Further, the factory doctor becomes an important consultant of Management on safety measures, the effect of certain types of work on health, and in almost all welfare matters. In his privileged position of being in possession of confidential personal details concerning the employee, his advice is of inestimable value in dealing with personnel problems.

If the factory doctor's advice is to be acceptable to Management, however, his approach to the job must be tuned to the requirements of industry just as much as that of the other department managers in the factory. The costs of the medical department are every bit as important as the costs of the engineering and maintenance departments or, for that matter, any of the production costs. The industrial Wage Bill has already soared to unprecedented heights and any increased charges must prove their value by improving production or they will merely add to the cost of the product and further increase the vicious circle of the rising cost of living.

2. *Medical Benefit Funds*

The medical service at the factory, whether merely 'curative' in nature or a more pretentious 'preventive' scheme, has often been combined with a scheme for the provision of sick pay for employees financed through the establishment of a medical benefit fund. The provision of medical services at the factory will tend to reduce sick absenteeism, and the necessity of obtaining a certificate from the factory doctor to qualify for sick pay will offset the new incentive for the employee to absent himself from work on medical grounds.

The benefit fund is financed normally by equal contributions from employer and employees. Its two most important aspects are, firstly, the provision of medical services to employees at a known cost (being the amount of their contributions to the fund), provided that the fund operates within its financial resources and, secondly, that it takes over from the employer the legal obligation to allow up to 12 days sick leave per annum and pays its members sick pay in the event of illness on more generous terms and for longer periods than required by law.

From the employees' point of view, therefore, he insures himself, by the payment of contributions to the Fund, against irregular and unknown medical expenses and the possibility of a cessation of income due to illness. According to its financial resources, the fund may or may not cover specialists and hospital expenses. If it does, a further important financial burden is lifted from the employees' shoulders.

From the employer's point of view, always provided that the fund operates within its financial resources, the costs of the medical service are known and limited to the amount of his contributions to the fund and the welfare of employees is improved by the introduction of more generous sick pay provisions.

Benefit funds often increase the scope of their medical service by appointing a panel of doctors, instead of one factory doctor, so as to allow employees some freedom of choice of their medical practitioner. Unless the panel is very close-knit, however, a 'preventive' medical service becomes impossible and, except so far as general welfare is concerned, the usefulness of the scheme to factory management disappears because the intimate co-operation between the factory doctor and factory management on employee affairs no longer exists. The medical service ceases to be a department of the factory tuned to improving and reducing the cost of the product and becomes merely an additional charge to general welfare, being provided for goodwill purposes only. Where a benefit fund appoints a panel of doctors in addition to a factory doctor, it would be wise to permit only the factory doctor to issue certificates for payment of sick-pay. If panel doctors are permitted to authorize paid sick leave, that doctor who is most generous in this way will be the most popular amongst the employee members and panel doctors might inadvertently earn the reputation of competing for patients by unnecessary issue of sick-pay certificates.

Unfortunately benefit funds must, with normal financial prodence, place limitations on the benefits available to members in order to remain solvent. Sick-pay is therefore usually limited to slightly less than normal pay for the first 2-4 weeks of an illness and thereafter is paid on a reducing scale for a maximum of usually 3 months in any one year. Chronic illness is also normally excluded from benefit and, to prevent persons from joining the fund to obtain expensive treatment of existing ailments and then moving elsewhere, illnesses which pre-date membership of the fund are excluded. Certain medical expenditures are often regarded as avoidable or not essential to basic health and therefore not a reasonable charge to the fund; so that expenditures connected with maternity, treatment for sterility and cosmetic effect, V.D. and others are very often left to the individual to meet himself.

3. *Medical Aid Societies*

A medical aid society is a straight-forward insurance scheme. It is a two-way insurance: the medical practitioner is guaranteed against bad debts because the society undertakes to pay his accounts, and the member is insured against heavy medical expenditure.

The essential differences between a benefit fund and a medical aid society are that the society does not provide sick pay, nor does it employ a medical staff (except, of course, a medical adviser who interprets accounts received from medical practitioners and translates the nature of the illness so that the lay committee may apply the society's rules). Further, at the insistence of the Medical Association, a medical aid society incorporates the principle of free choice of doctor (the members may select any medical practitioner to attend them) and there is no question of a panel of doctors.

All trace of control by the society over the medical practitioners providing services for their members is therefore eliminated. Medical aid societies are fortunate that an extremely high standard of professional integrity is the general rule in medical practice, because a society's funds could be milked in a very short space of time if doctors providing services for its members practised over-visiting and other money-making methods. Against these possibilities the society has only two safeguards: firstly, a contract with the Medical Association laying down a tariff of maximum fees for all possible medical procedures—the elimination of bad debts enables the medical profession to offer lower fees than normally charged in private practice—and secondly, by requiring the member to pay a portion of the accounts himself. This second safeguard has its limitations, because the normal insurance practice of requiring the insured to pay the first £5 (or whatever the relevant sum would be) serves no purpose. The society therefore fixes a proportion of the account which it will carry itself and requires the member to refund the balance. The society then hopes that should a medical practitioner indulge in over-visiting or some other

malpractice, the member will find himself a new doctor. There is however a flaw in this latter safeguard because if a doctor should visit him more frequently than is strictly necessary, the member's ego is probably inflated by the doctor's apparent concern for his welfare.

The problem of collecting that portion of the medical accounts refundable by members (and ex-members who obtained treatment immediately before withdrawing from the society) is one of the major difficulties facing any society which tries to adopt this method of indirectly controlling medical expenses. However, there are other reasons for requiring a member to make some contribution towards his actual expenses; namely, that few societies can afford to provide full cover and, further, the member is likely to be more appreciative of the work done by the medical practitioner and is less likely to abuse his privileges if it directly affects his pocket to some extent. This provision therefore operates in the interests of both the society and the medical practitioner.

The industrial employer need have little to do with the administration of a medical aid society and he makes it possible for his staff to enter such a scheme (or establishes one exclusively for them) in their interests and not his own. It is quite common practice for an employer to pay portion of the employee members' contribution to a medical aid society. The chief attraction of this type of medical cover to an employer is the fixed cost of the subsidy he pays. It should be stressed that an employer's investment in a medical aid society is recurring and merely a provision for treatment of employees' sickness. Having made this contribution the employer may, as a layman, consider that he has gone far enough. In fact he has not made an investment to promote the health of his employees at all; his contribution is a welfare expenditure and an added cost of production and must be regarded in this light.

An industrial employer may, however, establish or join a medical aid society in order to provide the specialist and hospital care not available at the factory medical department.

The medical aid society suffers from the same drawbacks as a benefit fund in having to restrict and limit benefits in order to remain solvent. The Achilles heel of a medical aid society is, however, the absence of control over chargeable services rendered to members. It is not unknown for a medical aid society to be forced to convert the nature of its organization to that of a benefit fund with a panel of doctors in order to avoid insolvency. I do not have to dwell on this point since the information is gleaned from the pages of the *South African Medical Journal* and the Medical Association is already concerned at the implications of such events.

APPROVED FEES FOR MEDICAL PRACTITIONERS

There are 4 bases recognized by the Medical Association for the payment of medical practitioners employed by or cooperating with one of the abovementioned schemes:

(*a*) As a full-time employee the doctor is paid a salary.

(*b*) As a part-time employee the doctor is paid at the rate of £2 2s. 0d. per hour.

(*c*) Doctors on the panel of a benefit fund may be paid £1 2s. 6d. per annum per European and 12s. 0d. per annum per non-European registered on their panel, or

(*d*) Panel doctors or doctors treating members of approved medical aid societies are paid a fee based on services rendered and calculated in accordance with a tariff of fees drawn up by the Medical Association for all possible medical procedures.

The complexities of completing an insurance claim (i.e. the medical aid society's claim form) so that accounts are presented in a form understandable by the lay committee of the society, are often irksome to the medical practitioner and, where incorrectly completed, lead to considerable delays in payment by the society. Whilst most doctors complete these insurance forms correctly, others, probably owing to lack of interest or lack of explanation, do not. This gives rise to delays which interrupt the whole process of approval and payment by the society.

On the other hand, the *per capita* fees allowed for panel doctors of a benefit fund are perhaps too low to provide any incentive for the doctor to pay anything more than a cursory interest in the general health and well-being of the member patients on his panel. In fact the panel doctor is intended only to provide a 'curative' service. An interesting illustration has been given by the British National Health Service where, it is reported, general practitioners have complained that the scheme does not allow the time or the remuneration for patients who demand a 'check over'.

ADMINISTRATION EXPENSES

The proportion of revenue absorbed in administering medical aid societies and benefit funds has an important bearing on the finances available for the provision of benefits. The marginal cost of administering a benefit fund for factory employees may be so small as to be disregarded. The work connected with the fund's accounts can be quite easily undertaken by the existing factory accounts clerks and the payment of sick-pay can be absorbed into the pay-office routine without an increase in staff. If the fund is administered by a committee, the committee members are normally appointed or elected in an honorary capacity. The marginal cost of administering the scheme might therefore be merely the few shillings spent on additional stationery.

A medical aid society on the other hand must face heavy costs of administration; according to the size of the scheme, these may absorb between 20% and 35% of the society's revenue from contributions. A society must have at least 2,000 members in order to achieve a reasonable spread of the insurance risk. It follows that few concerns are of sufficient size to establish an internal society without the risks being unduly concentrated. Medical aid societies are therefore often established to cover a group of smaller concerns, and the maintenance of membership and contribution records becomes more complex and probably a full-time job for one or more clerks. A trained and experienced staff is required to check and assess the benefits on claim forms received, and a complex system of controlling benefits to within the maximum limitations imposed by the rules must be instituted. The sums of money invested in office equipment are sometimes very large. Payments must be made to a wide circle of medical practitioners and the services of a medical referee (whose duty is not the provision of benefits) must be retained. The work done by the committee may reach proportions where it becomes necessary for the society to pay fees to committee members.

A very large society, spreading administration costs over a large number of contributors, may be able to operate on 20% of its income, but the ordinary society can be congratulated on its efficiency if it manages to keep its administration costs below 30% of its contribution income.

Other Medical Schemes

I have for convenience grouped all medical schemes under 3 headings (see above) namely: (*a*) The factory medical service financed directly by the employer, which may be regarded as an ordinary service department in the factory; (*b*) the benefit fund financed jointly by employer and employee, and (*c*) the medical aid society financed by premiums paid by the employee (normally subsidized by the employer).

There are of course a variety of other schemes but most of them contain the basic features of one or other of these three or a combination of them. One of the societies with which I have been associated, supplements the services provided by the factory medical department, and bears part of the retaining fee paid to the factory doctor, a portion of the cost of medicines and the full cost of specialist and hospital care. The society also provides sick-pay privileges and caters for the employees' families. Comprehensive statistical records of all attendances, illnesses, treatments and absenteeism are maintained at the factory surgery. All employees and their families are medically examined on arrival and thereafter once annually and may obtain free medical treatment at the surgery. The scheme is run on 'preventive' lines and detailed medical records are kept for each individual employee and his family.

In order to introduce the 'medical aid' aspect and allow freedom of choice of general practitioner, this society has extended its scheme to provide what it calls its 'domestic medical service'. Any local general practitioner who wishes to cooperate with the society may have his name added to the open panel providing this service. Employees may, as an alternative to obtaining free treatment at the surgery, call in any panel doctor who, in order to keep the factory records complete, keeps the factory doctor informed of all services provided to employees and their families. This is done by routing accounts for services rendered through the factory surgery, where they are checked and the details inserted on the

record cards. For the same reason, all cases recommended by panel doctors for specialist or hospital care are routed through the factory doctor. 50% of the panel doctor's fees are, however, recovered from the employee patient because these fees cost the society more than double what it would have cost had the necessary treatment been obtained at the factory surgery.

Thus this society attempts to combine all the advantages of the 3 main types of scheme listed above. From the date it introduced its domestic medical service this Society has been threatened by financial difficulties. These difficulties do not arise solely from the extension of its scheme to provide a free choice of doctor because there has been an increase in the number of families dependent on the society to carry their medical expenses. Rising hospital and specialist fees have also taken their toll. Nevertheless, an analysis of the society's accounts shows that the introduction of the medical aid aspect has proved to be a major drain on the society's finances.

SUMMARY AND CONCLUSIONS

Industrial medicine—if I may use that phrase to describe the functions of a factory medical department whose objects are to maintain and promote the health and happiness of employees, keep them at work and, as a natural corollary, improve their efficiency—industrial medicine is a relatively new field for exploitation by medical science. It is perhaps not a new approach and has been used before, but its potentialities have not been fully exploited in South Africa. By striking at the root of industry's absentee problems, the medical profession could provide a valuable service to South Africa's productive enterprise by fostering the development of this branch of its activities. It will, however, be necessary to give further thought to the organization of industrial medicine and the complementary benefit funds and medical aid societies.

Firstly, as I have tried to illustrate, the cost factor is the governing element. If industrial medicine is to be a 'healthy' development in itself, its costs, like those of the engineering departments and consulting engineer's fees, must not represent an increase in the cost of production. Its activities must result in, and its cost be absorbed by, improved production. The object must be a lower-priced product through the improved productive efficiency of labour.

Secondly, the importance of industry's absentee rates and the growth of the industrial population indicate that there is a tremendous untapped field for medical practitioners specialized in industrial medicine. Where a factory is not large enough to employ a full-time doctor, a doctor specialized in this type of work will not fail to find several factories demanding the services of a part-time doctor. It is important to these factories that the factory doctor be a specialist, or at least experienced, in this field because he takes charge of a factory department and not an ordinary surgery. An experienced factory doctor who understands the workings of a factory, general personnel problems and the importance of cost and statistical analysis, would earn his £2 2s. 0d. per hour, whereas the family doctor with no experience of factory problems would not.

Thirdly although the Union Health Department has done some research in the field of industrial medicine and has shown that much can be done in this way to alleviate the problems of absenteeism and even labour turn-over, it remains with the profession to prove its value. It follows that a medical practitioner who undertakes to provide services for an industrial medical scheme must understand the nature of the problems involved and re-tune his approach to the needs of productive efficiency. The industrialist too must be educated to the requirements of industrial medicine and be shown that the payment of a subsidy to a medical aid society is not an investment but a goodwill expenditure and an added cost of production.

Finally it becomes apparent that the Medical Association will have to give further thought to its policy of insisting wherever possible on a free choice of doctor. This policy implies apparently that its members may participate in all medical aid schemes (at a fee lower than that charged in private practice), although such work may not fit in with the ordinary practice of any particular member and the medical aid management must employ medical practitioners who may not be interested in promoting the success of the scheme in question. There appears to be some moral obligation on the medical practitioner to undertake medical aid society work at tariff rates, although he may refuse to do so. The medical aid management may not, however, advise its members that it will not be responsible for payment of fees to any particular doctor. This unusual arrangement may not promote amicable relationships between doctors not particularly interested in this type of practice and the scheme's management.

It is normal insurance practice for the insurance company to nominate the party who will provide the required services to the insured. Presumably there is no legal obligation for a medical aid society to do otherwise, except the terms upon which the Medical Association will approve the scheme, and such approval is necessary before the Association permits its members to participate in the scheme and reduce their charges to medical aid rates. Further, it is important to the lay management of a medical scheme to have the support of the Medical Association, and they would in any case wish to cooperate with the Association to the fullest extent. Nevertheless it would seem to the layman that the mutual interest of the profession and medical aid schemes would be better served if more ordinary rules of contract were given a freer play.

Instead of asking that all members of the Medical Association participate in every medical scheme, each scheme's management might be encouraged to establish a panel of doctors for that scheme. Any doctor who is not interested in this type of work or in that particular scheme, need not have his name added to the panel and the scheme's management, after proper advertisement, will select from the applicants a panel of doctors wide enough to provide adequate freedom of choice for members and comprised only of doctors interested in that particular scheme's success. Where the relationship between the scheme and any of its panel doctors is an unhappy one, they can sever their connection without difficulty. A bad scheme will soon fail, because doctors will have their names withdrawn from the panel and the Association can draw the attention of the scheme's management to its deficiencies, and possibly, circularize its members pointing out the difficulties that have been experienced by doctors on that particular panel. A good scheme will succeed through interested cooperation of the panel doctors and scheme management for their mutual advantage. Such an approach would provide a freedom of contract for industrial schemes which they have so far not enjoyed and would go a long way to solving some of the administrative difficulties experienced by medical aid societies and benefit funds.