IMPRESSIONS OF A PRESIDENTIAL YEAR

DR. J. H. STRUTHERS SURVEYS THE MEDICAL POSITION IN BRITAIN AND SOUTH AFRICA

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The period of my office as President of our Association will be terminating early in October. It would be difficult and would take quite a time to review the many important problems and policies that have been examined and discussed during the year. However, as I have been fortunate enough to make an overseas trip during my presidential year, I thought I would confine myself to giving you some impressions which I gained concerning the National Health Service in Britain and also mention one or two of the more important matters which have engaged our attention here.

The first and most important event of the Presidential Year was the Medical Congress which was held in Pretoria in October 1955. This was rightly assessed as a most successful congress. The scientific meetings were very well attended and the stimulus of our overseas visitors and speakers helped towards a most stimulating academic week. The very large number of papers read made it somewhat difficult for individuals to choose which to attend and the interest displayed both locally and from all over the Union, was most gratifying.

The Pretoria Branch and especially the Organizing Committee, did a real job of work for the Association and to them we are most grateful.

Since the Congress, I have had a number of invitations to attend Branch functions and I very much regret that I have not been able to accept these invitations as frequently as I would have liked. I think that the suggestion that the President should visit the Branches during his term of office is very sound, and I was disappointed that my trip overseas this year made this impossible.

During my stay in Britain, I had an opportunity of meeting members of the Council of the British Medical Association, including the newly-elected Chairman of the Council, Dr. S. Wand, who had been a fellow student with me 35 years ago; of attending meetings of the Representative Body which discusses the problems of the profession, and finally determines the British Medical Association policy; of meeting numerous medical colleagues and friends, as well as attending the B.M.A. Congress at Brighton as the South African representative.

The Congress was well organized; it had its highlights, and the hospitality we received both in Brighton and elsewhere was most generous and delightful.

From a perusal of the publications of the B.M.A. and from listening to the debates of the Representative Body, I felt that the Medical Profession was much more inclined to give a lead on medical matters in relation to public policy. Joint Committees are set up to discuss public policies and problems such as the one appointed annually by the Councils of the B.M.A. and the Magistrates Association to consider matters of common interest especially cruelty to and neglect of children.

I felt the discussions and debates were more altruistic and less inclined to be restricted to purely professional interests. Although medical men were encouraged to give a lead in the community life, the profession was no more inclined than we are, to permit such activities to become a possible source of advertizing for the doctor and this was most jealously guarded.

NATIONAL HEALTH SCHEME

The National Health Scheme has been in existence in Britain for the past 8 years, and I was most anxious to form some estimate of its success. The Medical Secretary of the B.M.A. said he could give no estimate as to whether the profession as a whole approved it. It certainly has lots of supporters, both in and out of the profession, but it also has its critics.

Amongst the public, the young married people, especially with families, seemed to consider it was excellent. Their doctor gave them a good service and to have no financial worries in illness and in producing babies and in rearing children, was a Godsend.

On the other hand, some of the older people, especially those of the middle class, were very much less enthusiastic. Apparently a consultation with a specialist meant a visit to the Out-Patient department of the hospital, not to the specialist's consulting rooms, which was what they had been accustomed to.

If the general practitioner could justify a consultation with the specialist at the patient's house, this was more satisfactory as the patient was happier and the specialist got a fee from the Health Service of £4 4s. 0d. If hospitalization was advised, then there was usually a long wait for a bed which, however, could be obviated by the patient becoming a private patient and so paying for the accommodation and the treatment.

It is interesting to note that the British United Provident Association, under the Presidency of the Right Honourable Viscount Nuffield was formed by the amalgamation of a number of Provident Associations in 1947. It is a non-profit association to shield subscribers against specialist treatment and hospital

and nursing-home costs. Benefits paid in 1950 amounted to £86,000. In 1954 they amounted to £800,000 and now they are over £1,000,000 annually. This does suggest that a considerable number of people consider some provisions of the Health Service Scheme are inadequate.

As regards the medical profession, it would appear that established general practitioners are probably reasonably satisfied financially and assistants are often available to them without it being a crippling expense. Consultants have been appointed often to combined posts in the smaller urban and more rural hospitals which has been of help to both patient and doctor in these areas.

There was a tendency for doctors in assessing practices, to count heads. The loss of a dissatisfied patient was only a loss of £1 per annum—a comforting thought. However, many disadvantages were apparent. The mobility of the general practitioner seemed to have disappeared. Once in a practice, there seemed no means of moving. The chance of up-grading oneself by transferring from a strenuous working class area to a more pleasant residential town, perhaps after many years of practice, just did not exist.

Also, no doctor could expect his son to succeed him in his practice unless he had got permission to take him in as a partner whilst he himself was still fit and well.

PRACTICES CONTROLLED

All practices are controlled by local committees which include senior general practitioners. There might be 150 or more applicants for a vacant practice, and in one case discussed, this number included 37 applicants with higher degrees.

However, as general practice is sometimes considered a speciality of its own, a man with a higher degree and some years as a registrar was often not shortlisted, as he might not be considered trained for general practitioner work.

The problems for the young doctor were very great and it seemed that his best chance was to find some principal whom he could persuade was overworked, required a partner, and would invite him into partnership. Otherwise you had to be extremely lucky to get in.

Other disadvantages were that there were no advantages or 'merit awards' to the general practitioner, no matter what he did to increase efficiency or gain experience. The newly starting doctor gets the same in every particular as the most highly qualified and experienced general practitioner. Also, the provision of excellent clinic and consulting accommodation was merely an additional expense on the doctor which almost resulted in a premium on inefficiency.

As far as specialists were concerned, the established consultant with a senior hospital appointment seemed satisfied. Private practice could still satisfactorily augment hospital part-time salaries and registrars diminished the stress of hospital routine. Further, the knowledge that medical investigation and treatment was available to everybody through the National Health Service was very satisfying.

There are roughly 20,000 general practitioners in the British Health Service. The specialists and consultants in the Service all hold paid posts on one or other of the hospitals. There are 3,000 senior registrars who are fully trained specialists, many of whom have been acting as consultants for 3 or 4 years or more, who cannot get promotion to hospital posts, as these are limited and filled, and who therefore have to exist on a salary of little more than £1,000 per annum.

In England, to practice as a specialist or consultant in the Health Service, a doctor must hold a hospital post in his speciality —these are limited in number and all are filled save for normal wastage.

The effect of this on South Africa is interesting. Consultant Heads of Departments in the British Hospitals are loath to appoint registrars from Britain unless they find they can guarantee a consultant hospital post at the end of the specialist training. The hospitals, however, still require an adequate complement of Registrars and so a South African or any other overseas candidate with a higher degree stands quite a good chance of getting such a post, providing they are ultimately returning to South Africa or their own country to practice.

QUESTION OF OVER PRODUCTION

This now links up with a problem which has concerned both the profession and the Federal Council of our Association and that is the question of over-production both of doctors and specialists.

New medical schools have been established without perhaps, very much reference to or investigation of, the requirements of South Africa as far as doctors are concerned, and there is a growing feeling that already, at any rate in the economic field as things now stand, saturation point may have been reached.

Regarding specialists, South African hospitals are now training a large quota of specialists and if to these are added an increasing number of doctors who can fulfil the specialist register requirements with overseas appointments, it may be that serious practical and economical problems are going to arise from the possible over-production of specialists. This is also a problem which is worthy of consideration and perhaps investigation by the profession.

One very important subject that has been discussed by the profession in the branches and in the Federal Council during this year, has been Insurance against sickness, and in April this year, Federal Council accepted the report of its Sub-committee on the Economics of Medical Practice and decided it would sponsor such a plan.

Sickness insurance has existed in South Africa for a very long time in two main forms:

(*a*) Benefit Societies which provided a service on a salary or a per capita payment basis and which in consequence gives a limited choice of doctor or no choice, to the patient, but makes no further financial demand on the patient beyond his monthly contributions;

(*b*) Medical Aid Societies which pay the doctor on a per service basis, gives an entirely free choice of doctor to the patient, as in private practice, but may impose certain controls upon the patient and or the doctor.

The Medical Association completely supports the free choice of doctor principle and has, for the past 10 years, encouraged and fostered the medical aid plans as providing a better service and a better doctor/patient relationship.

This second plan pre-supposes the creation of a complete schedule of fees. Ten years ago, when a schedule was drawn up, the profession agreed to a preferential tariff somewhat below private fees, because they wished to encourage lower-paid workers to insure against sickness. During the last 10 years, two important changes have occurred:

1. The cost of living has doubled but the tariff has been upgraded very little and then only in the face of great opposition from the Association of Medical Aid Societies.

2. The range of membership of these societies has so increased as to now include the majority of those who were, 10 years ago, the normal private patient.

DOCTORS' FEES

It would thus appear that what is required today, is not so much insurance for the lower and lower-middle income groups at reduced fees, but adequate comprehensive insurance against sickness for the whole population as far as they wish, at adequate 'per service' fees for the doctor, which shall bear proper relationship to standard private medical fees.

It will be for Federal Council, with wisdom and foresight, to try and convert this into practical application.

I would stress that a complete schedule of fees is essential to such a scheme and to assess the fees of each speciality in proper and reasonable relationship to each other is of first importance and our ability to do this may very well become the indication of our unity as a profession. I believe that unity in the profession makes for strength.

I would like now to thank all the members of the Association for the splendid support they have given during this year. Especially would I like to mention the Medical Secretary, Dr. Tonkin, who has always been so helpful and my partner, Dr. Kelsey Loveday, who made my overseas trip possible. And in expressing to you all my thanks, I would like to wish the Medical Association of South Africa a continuing programme of fruitful achievement.