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SCHEDULE OF FEES

In 1960 the Snyman Commission was appointed to inquire into the high cost of medical services and medicines, and in the same year the Reinach Commission was appointed to investigate, consider and report on the combating of the high cost of medical services and medicines by means of (1) medical aid and benefit societies; and/or (2) insurance companies.

Following the findings of these two Commissions, the Government decided to establish the Central Advisory Council for Medical Aid Schemes, with Dr. N. Reinach as its Chairman. The function of this Council is to investigate the possibility of extending medical aid to all Whites, irrespective of income, and to control these schemes. Legislation was contemplated in which the principles, on which extension of medical aid membership to all Whites is to be based, were to be embodied. In order to administer an Act of this nature it is necessary to refer to a tariff. The problem of formulating a tariff which might be used as a standard tariff was fully discussed at previous Federal Council meetings and it was decided to appoint a central Schedules Committee to draw up a suggested standard tariff of fees. The Schedules Committee consisted of Dr. J. K. Bremer (Chairman), Dr. W. H. Lawrence (replaced by Dr. S. Spiro), Prof. F. G. Geldenhuys, Dr. A. L. Agranat, Dr. H. Penn, Dr. J. I. H. Frootko, Dr. J. Chait, Dr. R. D. H. Baigrie, Dr. D. McKenzie, Dr. P. V. Suckling, Dr. F. E. Hofmeyr, Dr. H. J. H. Claassens, Dr. F. H. Counihan, Dr. K. T. Goldswain, Dr. J. Duncan, Dr. N. R. Pooler, Dr. N. G. Steere, and Prof. H. Grant-Whyte.

In order to start work at once this Committee started working in three regional groups, namely the Transvaal, Cape and Natal groups with two corresponding members, Drs. K. T. Goldswain and F. Counihan. It should be noted here that this Committee was instructed by Federal Council to go ahead and draw up a tariff of medical aid fees (and also of private fees, which is not under discussion at present) without prior consultation with the various Groups within the Association. This is noted because it caused dissatisfaction among members of some Groups. The regional committees approached the problem by going through the then existing medical aid tariff book group by group and item by item, each group putting down its opinion on what a suitable fee would be and circulating its minutes to other groups. During February 1964 a meeting of the full Schedules Committee was held when members were in Cape Town for the Federal Council meeting. At this meeting the basis for the so-called Standard Tariff was discussed and the following proposal was accepted:

'That the Tariff suggested by the Schedules Committee is a "Standard Tariff applicable to all members of pre-paid medical schemes, irrespective of income level". It is not a Tariff which could be applied to any particular income group. It envisages the abolition of the existing Preferential Tariff.'

There was no time available for anything more than a general discussion which was largely confined to consultation fees in certain groups. It was agreed that the regional groups of the Schedules Committee would attempt to get through the rest of the medical aid tariff as soon as possible and that the Chairmen of the three regional groups would meet towards the end of April to finalize a proposed Standard Tariff which would then be sent to the various Groups for their comments. This proposed Standard Tariff was sent out during early May 1964, with the request that comments should be returned by about the middle of July 1964, the intention being for the Schedules Committee to meet early in August to draw up a tariff of fees which could then be discussed with Medical Aid Societies before the Federal Council Meeting in October 1964. The proposed Standard Tariff evoked a violent reaction in many quarters.

In fairness to Groups who wished to conduct a more careful investigation into the economics of their practices, the Schedules Committee decided to postpone the closing date for comment until 11 September and to hold the Schedules Committee meeting immediately before the Federal Council meeting. This decision to allow more time for comment has paid handsome dividends, chiefly in the form of investigations done with the assistance of firms of accountants based on questionnaires sent out to the members of the Groups.

It was subsequently decided to invite all the representatives of the Groups to have a general discussion with the Schedules Committee after the individual discussions had been completed. This was done on Saturday 10 October 1964. Following these discussions with the individual Group representatives and with all the representatives together, the Schedules Committee met on Monday 12 October 1964 (i.e. the day before the recent meeting of Federal Council which was held on 13 - 15 October, in Pretoria) to discuss what progress it could make towards presenting Federal Council with a schedule of fees or even with a skeleton schedule.

At the meeting of Council (13 - 15 October) the Schedules Committee presented a full and comprehensive report of its work. The Committee reported that it was unable at this stage to produce even a skeleton schedule, the main reasons for this being: (1) the lack of time for sufficiently detailed study of the facts at its disposal, (2) the lack of expert advice in the shape of some form of financial adviser, (3) the lack of sufficient exact evidence on many aspects of the problem, and (4) the fact that the actual value given for a particular fee is intimately related to the general pattern of payment for medical services in the country.

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Among the final recommendations of the Schedules Committee to Federal Council was the suggestion that an actuarial survey of the economics of medical practice, with particular reference to the drawing up of a tariff of fees, be undertaken by actuaries in cooperation with knowledgeable medical men appointed by Federal Council.

Federal Council discussed this recommendation fully and felt that it was necessary to produce a standard tariff of fees irrespective of whether the proposed legislation will be accepted by Parliament next year.

It was therefore resolved: 'That Federal Council forthwith appoint a firm of actuaries to draw up a standard tariff of fees. Further, that Federal Council appoint a Committee of three members of Federal Council to assist and advise whenever called on to do so by the actuaries —this Committee shall call on 2 elected representatives from any group to assist them in their advisory capacity when necessary.'

The Committee of three members of Federal Council was then elected and consists of Drs. J. K. Bremer, Mr. J. Wolfowitz, and Dr. S. Spiro. The intention of Federal Council in taking this decision was to set about the problem of formulating a tariff of fees in as objective and scientific a way as possible—by appointing a firm of experts (actuaries) who, in consultation with the Medical Committee of three and the representatives of the Groups, will correlate all the available information and draw upon whatever source of information they might think necessary.

SIEKTESERTIFIKATE

Die uitreiking van mediese sertifikate en siekteverlofvorms word dikwels as 'n onbenullige ergernis beskou, waarvoor daar meesal geen vergoeding is nie, maar wat inbreek maak op 'n besige geneesheer se tyd. Baie werkgewers stel puntenerige eise wat betref die vorm, die nodige besonderhede daarop en die getal afskrifte van die vorms wat ingevul moet word. Datums moet by tye verstrek word wat selfs die aanvraer van die vorm ontgaan het. Die aard van die siekte lewer probleme op waar kwale soos alkoholisme, angsneurose en hoofpyn nie vir verlofdoeleindes in ag geneem word nie.

Die geneesheer se geduld word ook op ander maniere op die proef gestel. Hoewel sertifikate met die medewete en goedkeuring van pasiënte uitgereik word, wil baie van hulle nie die vertroulike aard van hul siekte geopenbaar hê nie. Party maak op verlof aanspraak, nie omdat hulle ongesteld is nie, maar omdat dit hulle kwansuis ‚geskuld word' deur hul werkgewers. Ander vra om 'n mediese sertifikaat vir 'n siekte waarvoor die geneesheer nooit geraadpleeg is nie. Versekeringsmaatskappye doen vertroulik navraag na bydraende doodsoorsake van afgestorwenes, wanneer polisuitbetalings geëis word. Dan het dokters ook 'n hekel aan diegene wat die spesifikasies op 'n siektefondsrekening verander wil hê, om by hul omstandighede te pas.

Daar kom hoofsaaklik twee oorweginge by die geneesheer op wanneer hy sertifikate en verlofvorms uitreik: Eerstens, wil hy graag in die beste belang en tot voordeel van sy pasiënt die aangevraagde inligting verskaf. Tweedens, is hy bewus van die altyd-teenwoordige bedreiging dat hy die pasiënt kan verloor as hy die vorms nie na wens voltooi nie—'n soort afpersing wat veral in die stede nie ongekend is nie. Daar steek dus heelwat meer in die vorminvullery as wat op die eerste oogopslag blyk.

Daar behoort teen gewaak te word dat genoemde oorweginge, veral dié wat op jammerhartigheid vir die pasiënt gebaseer is, 'n geneesheer nie oorreed om onjuiste inligting te verskaf nie. Deur hul goeie bedoelings trap sommige dokters onnodiglik oor die tou en bring hulle die professie in die verleentheid.

Omdat onbehoorlike sertifisering van tyd tot tyd tot moeilikheid lei en klagtes teen sekere geneeshere by die Tugkomitee van die Geneeskundige Raad ingebring word, dien kollegas weer eens te let op die vereistes vir behoorlike sertifisering, soos uiteengesit in die *Handleiding tot die Handhawing van Etiese Norme,* op pp. 13, 17 en 19. Let bv. op dat daar kennis geneem kan word as 'n geneesheer in sy professionele hoedanigheid 'n sertifikaat uitreik, tensy hy as gevolg van persoonlike waarneming oortuig is dat die feite daarin korrek is, of die volgende aantekening op die sertifikaat aangebring het: ‚Soos deur die pasiënt aan my meegedeel' (Item 17, p. 13). In die beginsels van mediese sertifisering behoort geheimhouding binne die perke van die landswette gehandhaaf te word; noukeurigheid en objektiwiteit is 'n vereiste; daar behoort onderskei te word op 'n vorm watter gevolgtrekking op die geneesheer se ondersoek berus, en watter op die pasiënt se verklaring; die geneesheer moet nie alleen die naam, geslag, beroep, ouderdom en adres oor die persoon aanteken nie, maar ook of hy die persoon vantevore geken het; die datum van ondersoek, die datum van uitreiking en die handtekening en adres van die geneesheer moet almal in 'n duidelike leesbare handskrif op die sertifikaat verskyn. Sulke sertifikate behoort altyd beperk te bly tot sake waarby mediese kennis en oordeel ter sprake is.

MEDICAL BENEFIT SOCIETIES

At its recent meeting, held in Pretoria from 13 to 15 October, the Federal Council of the Medical Association reconsidered and reviewed its attitude and basic approach to the Benefit Societies. After a full discussion Federal Council decided to withdraw its approval of all Benefit Societies as benefit societies. The Association, however, continues to approve medical aid societies which comply with the conditions prescribed by the Association.

This decision reflects a statement of policy which means that the Federal Council of the Medical Association wishes to make it known that it prefers the medical aid society system to a medical benefit society system. The Council feels that it is in the interests of both doctors and patients to change to the medical aid system. The main difference between the two types of societies, as is well known, is that members of a medical aid society have a

free choice of doctor and that services to patients are rendered on a per service basis. This form of medical practice, therefore, conforms to the principles of medical practice to which the Association has always given preference.

The most important points of criticism that have been levelled against the medical benefit system are that the Association has always preferred an open panel to a closed panel form of practice and that some doctors employed in a full-time or part-time capacity by benefit societies often have so much work on their hands that they cannot give the services needed in each individual case. Moreover, payment to part-time doctors by benefit societies is often so low that not only are doctors grossly underpaid for their services, but other sections of the public are, in fact, also subsidizing members of benefit societies by having to pay higher medical aid or private fees than would be necessary if the benefit societies were paying reasonable salaries.

The Medical Association hopes to persuade the medical benefit societies to convert to the medical aid system, and is prepared to negotiate to that end.

BOARD OF CONTROL OF MEDICINES

Soon after the publication of the Report of the Commission of Enquiry into the High Cost of Medical Services and Medicines, the Report was discussed by the Federal Council of the Medical Association. Federal Council agreed that the Report be referred to the Parliamentary Committee and also that it should be discussed in various Branches of the Association and that the Branches be asked to submit their comments together with any recommendations that they might wish to make to the Parliamentary Committee. This decision of Federal Council was made known to the various Branches and several of them submitted their comments.

At its meeting held in January 1964, the Parliamentary Committee again discussed the Report of the Commission of Enquiry in detail and also gave careful consideration to the reports thereon submitted by the Branches. The Parliamentary Committee then resolved that Federal Council be informed that in the opinion of the Committee the effect of the Report of the Commission of Enquiry into the High Cost of Medical Services and Medicines on the medical profession has been adequately dealt with by Council during its previous debates on the proposed Medical Schemes Act.

At its recent meeting held in Pretoria from 13 to 15 October, Federal Council discussed the implications of the recommendation of the Commission (recommendation no. 37) that a Board of Control of Medicines, representative of the expert groups in the country, be established under the supervision of the State Department of Health. In particular, recommendations 32 and 35 were discussed, in which the Commission recommended that the proposed Central Board for the Control of Medicines should fix and limit the permissible number of identical preparations (recommendation no. 32) and that the pharmaceutical industry be compelled by law, before marketing, to display the generic name as the chief name of a product, and also in the advertising literature and on containers (recommendation no. 35).

Federal Council felt that it would, of course, welcome any legislation which was intended to insure the greater safety and efficacy of drugs. In view of the fact, however, that the recommendations referred to above (32 and 35) may have a far-reaching effect on the professional freedom of medical practitioners, Federal Council felt it should make clear its views on this matter in the event of any legislation being contemplated in this regard. At the conclusion of the debate Federal Council resolved:

'This Federal Council, while it welcomes and endorses the principle of the establishment of a Drug Control Council in both the professional and the public interest, urges the Minister of Health not to include in the proposed legislation provisions which will give the Drug Control Council the right to interfere with the free choice of drug by the medical practitioner, who must be unhampered in his freedom to choose what is in the best interest of the patient.

'This Federal Council also urges the Minister of Health not to include in the proposed legislation any provisions which will facilitate or encourage the malpractice of substitution which must result from undue emphasis on or the exclusive or chief use of the generic names of drugs.'

This resolution reflects the policy of the Medical Association and its journals in the matters under discussion.

CENSUS OF MEDICAL PRACTITIONERS AND DENTISTS

From time to time the Bureau of Statistics receives requests for statistical information regarding the various professions, among others, the medical profession. For this reason and also for the very important purpose of estimating the contribution by the medical and dental professions to the national income of the Republic, and the expenditure by the public on health services, the Bureau decided to conduct a census of medical practitioners and dentists. Announcements in this regard were published in the *Journal* on 4 July, 29 August and 10 October.

This census is one in a series planned to collect statistical information regarding the more important professions. Censuses of the legal profession, accountants and auditors and veterinary surgeons have already been concluded, and the census of architects and quantity surveyors will be carried out in the near future.

Proposals for the questionnaire which is being utilized for the census of medical practitioners and dentists were approved after a number of meetings convened by the Director of the Bureau and attended by representatives of the Medical Association, the Dental Association, and the Department of Health. The Association was represented at these meetings by Drs. J. T. M. de Villiers, W. A. Lombard, P. D. Combrink and L. M. Marchand.

It is compulsory for all practitioners to provide the necessary information. We should, however, like to appeal to all members of the Association to cooperate fully and to make the required information available as soon as possible.