Cost of Effective Primary Care from Now to the Year 2000

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SUMMARY

The cost of primary care to a patient involving a group of 4 family general practitioners is discussed.

Standard tariffs, medical aid fees, hospitalisation, computerisation of medical records, staff and postgraduate training, all of which must be accounted for out of a doctor's earnings, are analysed.

S. Afr. Med. J., **48**, 1541 (1974).

The family practitioner has the responsibility of providing effective primary care to members of the family unit, whereas the Department of Public Health is concerned with community health, more especially the prevention, control and notification of infectious diseases, etc. Family practitioners, however, extend the effects of preventive medicine by immunisation and family care.

The cost of providing adequate private services will be discussed, with reference to a group of 4 family doctors practising in Johannesburg, a city with a population of about 1,5 million, consisting of equal numbers of Whites and non-Whites.

The following items constitute essential expenditure:

Rent of consulting rooms, which in our experience constitutes not less than 5% of the total fees earned.

Staff salaries, which in our practice are constituted as follows: 2 full-time State-registered nursing sisters, 1 full-time bookkeeper, 1 part-time bookkeeper, 1 telephonist and receptionist, and 1 general assistant. These salaries total approximately 10% of gross fees earned.

Telephone, two-way radio transmission services, postage and stationery constitute approximately 5% of gross fees earned.

Initial cost and maintenance of equipment, including items such as electrocardiograph machines, hyfrecator and cautery, haemoglobinometers, minor surgical equipment, diagnostic instruments, and disposable syringes and needles, dressings, swabs, etc. The estimated cost of these items, including depreciation, amounts to approximately 2,5% of gross fees earned.

Hire of motor cars, cost of petrol, car maintenance and parking. In order to obtain tax relief, relatively few motor cars are bought outright today. A large number of practitioners never actually own the cars they use, since they can hire them and exchange them at the end of the contract, a period of about 3 years. These expenses constitute approximately 10% of gross fees earned.

Drugs used in the course of the treatment of patients comprise approximately 8% of gross fees earned.

Insurance policies, including professional indemnity, accident and sickness policies constitute 2% of gross fees earned.

Sundry other expenses, including replacement of furniture and linen, laundry, magazines, bank charges, flowers, petty cash, etc., represent 3% of gross fees earned.

The above expenses total 45,5% of the gross earnings of the 4 partners working to capacity. The remaining 54,5% of the gross turnover can then be regarded as net earnings.

After subtraction of the estimated taxation, it becomes evident that the net income of each of the 4 partners is in the region of 10,5% per annum of the gross practice earnings.

The inevitable conclusion to be drawn is that, having provided for an annual holiday, and also rather inadequately for retirement, as well as maintaining an acceptable standard of living, very little remains for annual saving.

Thus it is apparent that the family practitioner is in a dilemma. If he increases his fees to more than those which his patients are able to afford, he is clearly defeating the purpose of providing a service to his fellow men. On the other hand, by virtue of the position he holds in society, and the fact that he is expected to live up to a certain standard, compounded by the spiralling costs of living, he might very well find himself unable to maintain a satisfactory living standard if his fees are not increased.

The family practitioner is responsible for providing a service to those patients who elect to come under his care, and traditionally contact is initiated by the patient. Family medicine services are usually rendered in the consulting room, or if the condition warrants it, in the patient's home. South African practitioners accept the necessity for home visits, as do their British counterparts.

Most White patients in South Africa belong to so-called Medical Aid Schemes or Benefit Societies, which are really sickness insurance schemes to which the member makes regular contributions and, in return, he and his family are covered for sickness benefits. These Medical Aid Schemes, which are privately owned, contract with individual doctors, the basis of the contract being the guarantee of the medical fee, provided that such fee does not exceed the preferential tariff laid down by the Remuneration Commission. Doctors do not necessarily have to contract with Medical Aid Schemes, but the big advantages are that the fee is guaranteed and payment is made directly to the contracting doctor. If the doctor elects not to contract with Medical Aid Schemes, he is entitled to charge his

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patients a private fee, but the arrangement is that the Medical Aid Scheme will only pay the approved preferential tariff rate and, furthermore, the sum is paid directly to the patient — a practice which leads to unscrupulous patients pocketing this money.

Guidance concerning acceptable private rates is given by the Medical Association of South Africa in their publication *Standard Tariff of Fees*. Table I shows a few examples of fees for services rendered under Medical Aid and Private Tariffs.

TABLE I. EXAMPLES OF FEES

	Members of a medical aid scheme	Non-members (average charges)
Consultation in rooms	**R3,00**	**R4,50**
Home visit	**R4,50**	**R6,60**
Night call	**R5,50**	**R8,50**

Many Medical Aid Societies do not offer complete coverage, excluding pre-existing disease, services not essential to health, etc. Very unjustly, wealthy directors of large firms are often accepted by Medical Aid Societies offering group Medical Insurance to the firm.

Medical aid annual subscription fees are approximately R28 per month for a family with 2 children and approximately R17 per month for individual members.

Two commissions were set up in South Africa during 1960 — the first to investigate all factors which are responsible for the high cost of medical services, and the second to investigate and suggest measures for controlling the high costs of medical and paramedical services and medicines to members of medical aid and benefit societies.

Both commissions were appointed on the presumption that medical costs were high, presumably in comparison with other consumer costs. However, there was little justification for this criticism, since the Snyman Commission reported that the *per capita* income had doubled during the two previous decades. Also from 1948 to 1959 money depreciated by 30%. A further sobering fact was that medical expenditure comprised only 2,59% of the family expenditure, as compared with 5,4% spent on tobacco, liquor and entertainment.

The average charge per day for a bed in a State Provincial Hospital is between R5 and R8 in a general ward, and between R8 and R10 in a semiprivate ward, the cost to the State being in the region of R17 per day. Patients in private nursing homes are charged an average of R15 to R20 per day.

There is, of course, a part of the White population who are unable to afford private medical care and do not belong to any medical aid or benefit societies. This category of patient is treated in the State-aided Provincial Hospitals, the patient's income being assessed and the hospital charges adjusted to a minimum of R1 - R3 per day for all medical and nursing services, etc.

Fees for Black patients are nominal. Those attending outpatient departments pay 20c per visit, and patients admitted to hospital pay 50c, regardless of the nature of treatment or operation. Medicine is provided free of charge.

It must be understood that most Black patients are unable to afford private fees, consequently they are treated at State-aided Provincial Hospitals. For example, at Baragwanath Hospital during the year 1970 to 1971, 77 500 patients were admitted as inpatients, 785 000 were treated in outpatient departments, and 73 000 were treated in casualty departments. Income received from above patients amounted to R268 000; however, total expenditure for the year was R7¼ million.

The family practitioner usually provides a far more personal service than does the staff of a hospital or a panel of doctors. To the family practitioner, the patient is an individual, whose life history is known and appreciated.

When admitted to a Government hospital or institution, the investigation of an illness may be prolonged, whereas in private practice the needs of the family are also investigated and constitute a foremost consideration. Thus investigations and treatment are rapidly performed, enabling the patient to return home and to employment as soon as is compatible with safety.

As the doctor of first contact, the family practitioner follows the course of an illness until the patient is fully recovered. In the case of benefit society and medical aid patients referred to specialists, the latter usually take over treatment, and thus subsequent visits made by the family practitioner are purely on a *pro deo* basis, as he is not reimbursed by the benefit or medical aid society.

Over the past 4 decades the prevention of disease, as distinct from its recognition and treatment, was regarded as a Public Health responsibility. However, with increasing medical knowledge concerning prevention of neoplastic degenerative disorders, as well as communicable diseases, it is suggested that the family practitioner has a role to play in increasing life expectancy, for it is the family practitioner who possesses the basic responsibility for comprehensive health care.

Most South African rural family practitioners perform their own surgery, unlike those in the cities where patients requiring surgery are referred to specialist colleagues. In South Africa there is a Register of Specialists, and it is the usual practice that specialists only accept patients who have been referred to them. However, this referral is not mandatory, and the patient is entitled to approach the specialist directly. Under these circumstances it is ethical for the specialist to inform the family doctor of his findings and any treatment intended, or already completed. If the specialist adheres to this ethical form of practice, it rebounds to the patient's benefit, as his family doctor is kept informed of all his medical treatment, and will be in a better position to handle the patient when he returns to his care. Specialist fees for a similar service are in the region of 66% in excess of general practitioner fees.

Western civilisation has come to regard diagnosis as the primary role of medicine. Precise detailed histories of each patient are an urgent necessity. Electronic data processing is capable of assuming an important role in this detailed medical history. A most important use would also be the handling of multiple data in conducting surveys and research.

The computer in family practice has three major capabilities. There is first of all massive storage of data, with rapid retrieval and rapid logical circulation. The development of a comprehensive, instantly available medical record covering the whole of a patient's life is possible; for periodic screening and to remind practitioners of routine tasks, regular check-ups and immunisations.

There is also automotive preparation of itemised practice accounts.

The major obstacle to computerisation would be the immense expense which would be prohibitive for the individual practitioner. The advantages and future possibilities of the computer are enormous. However, the introduction of an impersonal calculator must not be allowed to result in the loss of Medicine's basic humanity. It is paradoxical that in an age of increasing specialisation, it is likely that the future family practitioner will employ computer services long before his specialist colleagues.

The prime responsibility of the family practitioner is to his individual patient and, as such, it is his duty to ensure that his clinical standards remain as high as possible. It is also his responsibility to ensure that under- and postgraduate training of family practitioners, and continuing education, are of the very highest order.

The objectives are clear:

1. To complement traditional undergraduate education with training in family practice.

2. To establish teaching practices as complementary to undergraduate teaching hospitals.

3. Full paramedical and specialist services to be freely available, to enable the hospital to provide total, full, comprehensive care to a whole family unit.

4. To provide adequate, regular postgraduate teaching to the family practitioner, e.g. regular lectures and symposia; regular attendances at refresher courses, not less frequently than every 18 months; methods of keeping up with advances in medicine, including the reading of journals; and participation in clinical research trials.

In South Africa the medical fraternity is in a unique position in that there is a College of Medicine embracing all the disciplines of Medicine.

We, the family practitioners, have recently amalgamated with the College of Medicine, and we will be setting a precedent by offering two examinations; firstly, a Membership which affords the successful candidate entry into the Faculty of General Practitioners, and secondly, a Fellowship which will equate in standard and status with all other Fellows of the College of Medicine. It is our hope that the future may even see the discipline of Family Practice accepted as a speciality by the South African Medical and Dental Council.

In looking to the future, we must consider the society in which we live, for we do live in a changing world in the midst of social and medical revolutions, the significance of which we are only now appreciating. We now have a public that is more educated and thus expectant of a high quality of medical care.

In our planning for future organisation of medical care, we are uncertain exactly how family medical practitioners will relate to their patients. We need the knowledge in planning the patient's future as well as our own.

Advances in scientific and medical knowledge have led to the present era of increased specialisation, but paradoxically it has made us more aware that at the present time, and in the future, the patient's greatest need is for the general practitioner to be the first contact, for no matter what the cost of primary care, his services are an absolute necessity.

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