Editorial/Van die Redaksie

The Cape health blow

The south-easter is the wind prevalent in the Cape in summer; it is known as 'the Cape doctor'. Some hold that its name is derived from its beneficial effect in combating mildew of the vines, while others have noted that it dispels the smog over the city. A less healthy wind of change has recently been blowing strongly over the health care services of the Cape. Signs of the change in the financial climate were evident a year ago when a reduction in health care expenditure was announced by the authorities. But the real blow fell on 4 March this year when the Administrator, Mr Kobus Meiring, announced that a crisis situation had developed and that all public hospitals in the Cape were to accept only emergencies. While this was intended as an emergency measure until the end of the current financial year, of much more serious consequence was the simultaneous announcement that a further 10% cut in expenditure was required for the following year.

The reason for these measures has not been made public, and it is not known who took the decision and on whose advice. Facts and figures have not been provided, but it is suspected that it may have to do with the knowledge that there is a greater per capita expenditure on health care in the Cape than in the other provinces.[1]

The result of the emergency measures has been an immediate adverse effect on patients and the health care professionals. There are some similarities with the effects of the strikes by the health care workers who also 'allowed' emergency cases to be treated. At present there is at least no interference with the clinical judgement of health care professionals but it raises some very contentious issues. What exactly constitutes an emergency? The Red Cross War Memorial Children's Hospital in Cape Town treats hordes of children who arrive unannounced at its doorstep. Each child must be seen by a health care professional, since it would otherwise be impossible arbitrarily to determine who is really sick (see p. 405).

Should the young woman with early carcinoma of the breast be treated immediately? It could be argued that her case constitutes a psychological emergency. And what should be the stance when organs become available for transplantation? Not to use them, and in so doing lose them, could represent an emergency in the sense of the availability of a very scarce resource. In the smaller towns another unforeseen problem has arisen. Country practitioners have noted that the measures preclude them from treating their private non-emergency patients in the hospitals. Since these patients paid full fees to the hospitals there was no saving, but the doctors' incomes were threatened.

The most telling arguments against the emergency measures were that the money saved would be relatively little and that today's 'cold cases' were tomorrow's emergencies, which would have to be dealt with by fewer resources. Morale of the staff has suffered severely as a consequence.

Many of the woes of the present poor state of our health care services can be laid at the door of the ideological decisions — rather than decisions based on demonstrated need — taken in the past few decades. Thus health care services and medical schools have fragmented on grounds such as race and language. More recently the move to shift more health care responsibility to the private sector has further exacerbated the imbalance between the over-resourced private sector and the under-funded public sector, which carries the responsibility for the bulk of the population. In this context, the first glimmer of hope was the recent announcement by the Minister of Health, Dr Rina Venter, that public hospitals would henceforth treat patients without consideration of race, thus officially allowing the rationalisation of health care personnel and facilities and providing the first step in reversing the fragmentation of services.

There are perhaps three messages of hope discernible through the current clouds of confusion and despondency: (*i*) the Government is perceived to be serious about living within its budget; (*ii*) there appears to be a commitment to unify the health services of the country; and (*iii*) there is a stated resolve to provide adequate primary health care services for the community. Unfortunately, the latter two points have hardly been addressed as yet. Until they have, a reduction in the existing services holds the very real danger of damage that may be very difficult, if not impossible, to repair. Sir John Ellis[2] has noted that: 'Equality can be achieved by levelling down, but the price of its attainment is uniform inadequacy.'

For a variety of reasons the University of Cape Town has been fortunate in attracting and retaining good staff at its teaching hospitals. Cost is not the only factor, since there are teaching hospitals that are more expensive per patient.[3] Since other hospitals are already short staffed, there is not the same pressure to reduce their complement further, which is what is ultimately required in order to effect meaningful savings. It may thus be interpreted that to be successful will attract the greatest penalty. The public and through their pressure, the politicians, are tempted to concentrate on and to provide for short-term benefit. Herein lies the danger, since teaching and research may be regarded as temporarily expendable, although they are essential for the future. To quote Sir John Ellis[2] again: 'Its pressure is greatest when times are hard and money

is short, the very times when there is greatest need to decide priorities, and the greatest temptation to mortgage the future and eat the seed corn.'

It would be most unwise of South Africa to jeopardise some of its valuable patient care, teaching and research resources which Clem Sunter[4] has identified as one of our greatest assets. The Cape's hospitals, already under strain, will be harmed by the financial cuts. What is needed instead is a more realistic funding of the entire public health care sector, including hospitals in the other provinces, and a unified and more efficient and effective health care administration. Random cuts in expenditure without clear consideration of the consequences are 'an ill wind that blows nobody any good'.

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1. McIntyre DE. Public sector health care expenditure in South Africa, 1970-1990. Health Economics Unit Working Paper No. 1. Cape Town: Department of Community Health, University of Cape Town, 1990.
2. Ellis J. The responsibility of medical schools for teaching hospitals and the provision of clinical services. *Med Educ* 1991; **15**: 171-183.
3. Engelhardt H, ed. *Hospital and Nursing Year Book of Southern Africa*. Cape Town: H. Engelhardt, 1990.
4. Sunter C. *The World and South Africa in the 1990's*. Cape Town: Human & Rousseau, 1987.

The plight of junior doctors

The plight of junior doctors has been described as 'barbaric, scandalous and shameful in the extreme',[1] for over 6 decades, yet the dogged paternalism that vows: 'We suffered through it, so must you,' lives on.

The cry for just working hours and market-related, rational remuneration packages has been the rallying call for junior interns, interns and senior house officers throughout the world — a call that until very recently has gone unheeded and which still fails to draw attention in this country. There is no doubt that junior doctors carry the burden of first-line responsibility for public sector health care. Thus, high quality care is always required. In addition, the exposure rate to potentially lethal infections is also much higher. The implications for junior doctors and their patients towards the end of a 40-hour on-call period are disastrous.

Juniors are all still in the process of training and, despite the enormous opportunities available for learning in many of our provincial hospitals, experience by itself 'is neither education nor training'.[2] Clearly, the major burden of clinical responsibility falls on the shoulders of the intern and junior intern, both of whom should be consolidating their basic medical training, and not be chained to a treadmill.

The realities of the South African health care structure contrast vividly with many of the apparently rational approaches adopted world-wide. Some of these realities include:

- the continued iniquitous maldistribution of health care personnel and resources — mainly as a result of decades of bureaucratic racism and institutionalised apartheid
- the crisis in academic medicine which has seen 'disincentive' schemes in operation in the public sector
- the completely disproportionate doctor/patient ratio, which is unlikely to be corrected in the near future
- the economic recession, which motivates bureaucrats to continuously peg salaries of all health care workers at below market-related fluctuations
- a lack of political will and motivation on the part of the State to alter rationally the status quo in the health sector for fear of disturbing powerful lobbies with vested interests
- a vociferous, organised medical profession which is perceived by the broader public as being excessively 'money-orientated' and materialistic at the expense of intimate, effective patient care. This perceived scenario is often in direct opposition to the true position of most health workers, in particular junior doctors in the state hospital service
- entrenched sexism and racism, which prevent promotion and promote paternalism
- the crippling shortage of *good quality* nursing in many secondary and tertiary care centres in the public sector
- a lack of adequate supervision by seniors, most of whom work under similarly stressed conditions.

A recent British opinion of the junior doctor's position is that long hours are not as much the problem, as lack of support.

Most juniors gladly work the excessively long and demanding hours required of them, but discontent with regard to rational remuneration and reasonable conditions of service has reached flash point.

The Junior Doctors Association was founded in direct response to these demands and finds itself at a very early stage of its existence having to deal with these and other issues at local, regional and national level.

To rectify completely all these perceived problems overnight, would be naïve. However, the most basic areas requiring redress are those of *conditions of service* and *remuneration packages*. It is a sad indictment of the State and the South African Medical and Dental Council's parochialism that junior doctors have no contract or agreed terms of employment. The recent British model of agreed maximum working hours and additional *paid* overtime seems very attractive. 'Time-off' periods after calls need to be stipulated and leave-periods ensured. Systems of cover such as cross-cover while junior doctors are off, need to be assessed and debated.

While acknowledging the fiscal and economic crisis in the health care sector, junior doctors, together with all other health workers, need to demand a market-related salary that is commensurate with levels of training and work hours.

The reality is that in addition to suffering chronic fatigue, junior doctors in hospitals are expressing anger and resentment about their situation. The 'work-to-rule' model of a 60-hour week is an ethically controversial position, which many junior doctors are at present debating.