TO
THE LORD,
FOR
HIS GRACE.

AN INVESTIGATION INTO CONSUMER SATISFACTION WITH REGARD TO MEDICAL CARE PROVIDED BY PRIVATE MEDICAL PRACTITIONERS IN THE DURBAN MAGISTERIAL DISTRICT.

BY

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CHAPTER 1

INTRODUCTION

1.1. INTRODUCTION

Professor Weyers, Chairman of the South African Co-ordinating Consumer Council, recently had the following to say about consumerism in South Africa:

> "Consumers are finding it increasingly difficult to protect themselves from dangerous products, deception and economic exploitation. In seeking correction, consumers are amateurs, having to rely on their own knowledge and experience while facing professionals, competent in the newest business methods and technologies" (Weyers 1990:4-6).

Consumerism is clearly in its infancy in South Africa. Little formal research has been conducted into consumerism in general and even less into consumer issues relating to medical products and services. Yet a substantial portion of personal disposable income is spent on medical products and services.

In particular, private medical care appears to be utilised at an increasing rate, since it is now more accessible to the Black population as a result of increased membership of medical aid schemes.

Together with such increasing private sector patronage, however, there appears to be a growing disenchantment among consumers with regard to the circumstances pertaining to their treatment and constantly escalating medical care costs. Moreover, it has become evident that associations which fulfill vital roles in the administration of the private health care system, have neither the responsibility nor the initiative to systematically monitor consumer perceptions.

Numerous press reports suggest that the delivery of private medical care is assuming an increasingly entrepreneurial character. Accordingly, consumers might well suspect that profit maximization is now the main objective of doctors, rather than high quality of individual patient care.

1.2. OBJECTIVES OF STUDY

Traditionally patients trusted their doctors completely, in every respect of the reciprocal relationship. Consumer assertiveness would have been inconsistent with such a tradition. However, in recent decades, mass exposure to media reports has probably made the consumer less trusting and more demanding, even as recipients of health services. Accordingly medical consumerism could well become a major issue if dissatisfaction became manifest. With this in mind, it is fitting that current consumer perceptions of private medical care be empirically probed. In addition an assessment of consumer rights and responsibilities within the framework of existing legislation and practice needs to be undertaken.

If appropriately utilised and combined, marketing instruments can enhance the value of a product or service to consumers. The extent to which this might be true with regard to medicine will also be evaluated.

Patient satisfaction (disconfirmation) is fundamentally dependent on service quality which is "an abstract and elusive construct because of three features unique to services: intangibility, heterogeneity, and inseparability of production and consumption " (Parasuraman, Zeithaml, and Berry 1988:13). Service quality also stems from a comparison of consumer's expectations or desires from the service provider with their perceptions of actual service performance i.e. the perceived service quality is viewed as the degree and direction of discrepancy between consumers perceptions and expectations (Parasuraman et.al. 1988:5).

Although objective measures are not always available for determining quality, consumer perceptions are often considered to be appropriate measures of quality. Consequently this empirical study will focus on consumer perceptions of service quality.

1.2. LIMITATIONS OF THE STUDY

The study will confine attention to the Durban Magisterial

District. In doing so it is acknowledged that the perceptions of people in rural areas will be excluded. The perceptions of these patients may affect the general validity of the results, since rural medical consumers experience greater problems of accessibility, ability to pay and communication. It seems that such consumers also have a greater reliance on alternative forms of treatment (such as the use of witch-doctors), before consulting doctors. However, the findings of this study may be reasonably indicative of urban populations within South Africa.

1.3. STRUCTURE OF THE STUDY

The study begins with an examination of consumerism in general, since it is of central importance in this thesis.

The definition of consumerism is considered first, followed by an examination of the development, causes and goals of consumerism, as well as an assessment of corporate policy guidelines.

Chapter 3 examines consumerism in South Africa, and outlines consumer rights, responsibilities and the legal and practical framework within which consumers function.

Business responses in general, and in South Africa in particular, receive attention in Chapter 4. The implementation and enforceability of self-regulatory programmes and government regulations are also reviewed.

Chapter 5 reviews the health care system in South Africa, with particular emphasis on: the marketing mix of private medical care providers; and the rights and responsibilities of medical care consumers.

The delicate but fundamental relationship between doctor and patient is examined in Chapter 6. The consumer's propensity to evaluate the service encounter stems from the level of disconfirmation that ensues from this relationship.

Chapter 7 surveys consumer protection in the medical sector in South Africa. It will be seen that medical consumers too, may rely on both statutory and common law protection.

A normative model of the determinants of patient satisfaction is proposed against the background of the literature study, in Chapter 8. Numerous hypothesis based on this model will be stated and statistically tested in the empirical study which follows.

Chapter 9 is devoted to the research methodology to be implemented in the study. The empirical study will focus on the perceptions of patients who receive medical care from the private medical sector.

The research results will be analysed and interpreted in Chapter 10. Statistical tests will be applied in order to determine whether the various hypotheses will be accepted or rejected.

The concluding chapter will focus on the significant findings of the empirical study, with a view to providing recommendations against the background of the normative model.

1.4. CONCLUSION

Private medical care is viewed as an increasingly important aspect of the delivery of health care in South Africa. However, some aspects of the delivery of private health care are thought to be causing some dissatisfaction. The potential for the manifestation of these dissatisfactions in the form of medical consumerism is very real. Accordingly, attention first needs to be focused on aspects of consumerism.

CHAPTER 2

CONSUMERISM

2.1 INTRODUCTION

The rise and subsequent intensification of consumerism have posed many problems for many marketers as well as for the business community in general. To some marketers, it signals an acute danger, to others it is viewed as an opportunity for marketing. Some marketers feel threatened by public outrage and frustration, while others view consumerism as a step in the process of the dismantling of the free enterprise system.

It will be seen that the growth of consumerism is based essentially on the support of consumers. Lancaster and Massingham (1988:280) believe that the existence of consumerism bears testimony to the failures of marketing. While, at the same time, it has been responsible for marketing's increasingly important social dimension. In this regard some firms view consumerism as part of the new and broader dimension of

corporate-social responsibility, while others consider it to be a natural and inevitable outgrowth of our increasingly sophisticated and affluent society.

In order to gain a better understanding of consumerism, it would be appropriate to begin with a definition and then proceed with the development, causes, goals and corporate guidelines for marketers, of consumerism.

2.2 DEFINITION OF CONSUMERISM

Cravens and Hills [1970:21] define consumerism as "a social force within the environment designed to aid and protect the consumer by exerting legal, moral and economic pressures on business". Day and Aaker [1970:12] on the other hand view it as the "widening range of activities of government, business and independent organizations that are designed to protect individuals from practices that infringe upon their rights as consumers". While Buskirk and Rothe [1970:62] maintain that it is "the organized efforts of consumers seeking redress, restitution and remedy for dissatisfactions they have accumulated in the acquisition of their standard of living". More recently, Kotler and Armstrong (1990:605)

have maintained that "it is an organised movement of citizens and government to improve the rights and power of buyers in relation to sellers. Stanton, Etzel & Walker (1991:612) concur that "the consumerism movement protests perceived injustices in exchange relationships and attempts to remedy them."

Although various definitions have been proposed for the term consumerism, all focus attention on the responses of individuals and organizations to consumers' dissatisfaction arising from exchange relationships. Some definitions may however, encompass a wider scope, where, for example, societal responsibility issues are incorporated.

For the purposes of this study an eclectic definition of consumerism is: a combined set of activities of government, independent organizations, businesses and concerned individuals, designed to aid and protect consumers and society from perceived inequities in exchange relationships between buyers and sellers, as well as from potentially detrimental practices towards society at large.

2.3 THE DEVELOPMENT OF CONSUMERISM

Consumerism has existed for at least 41 centuries. An example of its early recognition is cited by Wentz [1979 : 531).

> "In 2100 BC, the code of Hammurabi, sixth king of Babylonia, states : 'If a wine-seller makes the measure for drink smaller than the measure for corn, they shall call that wine-seller into account, and they shall throw her into the water'."

Other authors too, (Pride and Ferrel 1977 : 448, Robin 1978 : 377 : Lancaster and Massingham 1988 : 280, Stanton, Etzel and Walker 1991 : 612) contend that consumerism was a force in society in both Europe and America well before the Industrial Revolution.

Although consumerism has clearly existed for many centuries, it has gained momentum only in relatively recent times. Indeed, it was not until the nineteenth century that the problems of consumerism were attended to with zeal, especially in the USA and Britain. For example, in 1898, in the USA, the first national consumer organization, the National

Consumers League, was formed. This League's first undertaking was the promotion of the enactment of pure food laws. While in Britain, in 1844, the first consumer co-operative was formed, which was regarded as having pioneered the modern approach to consumer protection. These organizations were formed in an attempt to deal with the underlying causes of consumer discontent.

2.4 CAUSES OF CONSUMERISM

Consumerism was born out of a combination of circumstances which will be briefly outlined below:

* Problems in the marketplace which were due to the growing technical complexity of consumer goods, manufacturing processes and the proliferation of products and materials, which in turn led to increased "acceptable performance thresholds" in the minds of consumers (Day and Aaker, 1970 : 15; Stanton, Etzel and Walker 1991:610);

* A lack of consumer information on product characteristics, prices and brands which made price and quality comparisons difficult, which in turn led to confusion and resentment (Marx and van der Walt 1989:93);

* A deterioration of business ethics such as the alleged avarice and irresponsibility of some marketers with regard to deceptive advertising, unfulfilled guarantees and dishonest or abusive selling practices which denuded the consumer of his rights (Lancaster and Massingham 1988 : 280);

* A tremendous upsurge in technological development led to a greater demand for better and more complex products. However this greater complexity produced a greater potential for malfunction and maintenance. Another cause of disenchantment in this area was the increasing depersonalization of business due to computerized systems and rigid customer policies;

* Problems in the social fabric were encountered through profound changes in society, such as higher education, greater reverence for the environment and an awareness

of the problems of disadvantaged communities. The problems of environmental pollution have become increasingly salient as the tolerance for these abuses decreased (Day and Aaker 1970 : 14; McCarthy and Perreault 1990:604). This area presents a continuing challenge to consumerism;

* Inflation accelerated in the 1970s in most countries of the world and this inflation was perceived by consumers to be primarily the result of inefficient, noncompetitive, exploitative ploys by highly concentrated industries. The effects of inflation had particularly serious consequences for the poor;

* Leisure time and rising incomes,particularly in the USA, in the 1980s, led consumers to respond to claims of expertise by manufacturers by expecting product perfection;

* Public concern of consumer issues was fuelled particularly in the USA by journalistic exposès, for example by Ralph Nader's, "Unsafe at any Speed" and Rachel Carson's, "Silent Spring". Threats to health

and safety were also publicized as a result of the devastating side effects of drugs such as thalidomide (Kotler and Armstrong 1990:606);

* Consumer advocates such as Ralph Nader (in the USA) achieved remarkable success in consumerism crusades. Political support for these forces of consumerism was secured and this generated a greater momentum for the movement. Even the professional service sector which had hitherto escaped the chagrin of activists was scrutinized and evaluated. Indeed consumer advocates in the USA published guides to doctor's fees and other details about doctors in the interest of consumers (Schrag 1970 : 425);

Stanton, Etzel and Walker (1991 : 612) believe that the present consumer movement will continue to address issues pertaining to

"* discontent with direct buyer-seller exchange relationships between consumers and businesses;

* discontent with non-business, non-profit organisations and governmental agencies; and

* discontent of those indirectly affected by the behaviour of others."

The rise of consumerism signalled a non-fulfillment of fundamental concepts which according to modern marketing thought ought to guide marketing efforts. In particular the marketing and societal concepts had been ignored. In this regard Drucker (1975:64) views consumerism as "the shame of marketing". He argues that if businesses behaved in strict accordance with the marketing concept, there would be no consumerism, adding that consumerism is irrelevant to the firm that truly meets the needs of its buyers.

2.5 THE MARKETING CONCEPT

Cronje et.al. (1990 : 133) view the marketing concept as "the ethical code or philosophy according to which the marketing task is performed."

The marketing concept is a term which pervades marketing literature and includes three fundamental ideas:-

a customer orientation,

a total company effort, and

profit, and not just sales, as an objective.

In firms where the marketing concept has been totally embraced, the entire company becomes a marketing organization. Marketing becomes the basic motivating force for the entire firm and it influences all short term and long-range company policies. But Stanton, Etzel and Walker (1991 : 9) point out that

> "As helpful as it is to stress customer satisfaction, the motto that the 'Customer is King' must not be allowed to replace achievement of objectives as the fundamental rationale for the marketing concept."

Flowing from this, the expectation of some proponents is that enlightened business communities will unequivocably accept and implement the marketing concept. However this is still to be seen. Moreover, those organizations which are perceived to have embraced the concept, vary widely in their interpretation and practice thereof, resulting in many forms and degrees of market orientation among the different firms which claim adherence to the marketing concept. The propen-

sity to adopt this concept will depend upon a clear understanding of it. However, Kohli and Jaworski (1990 : 1) point out that "Given its widely acknowledged importance, one might expect the concept to have a clear meaning, or rich tradition of theory development, and a related body of empirical findings. On the contrary, a close examination of the literature reveals a lack of clear definition, little careful attention to measurement issues, and virtually no empirically based theory." However despite this, some progressive firms on the other hand, have gone further and have in addition embraced the societal concept.

2.6 THE SOCIETAL CONCEPT

The more recent emergence of a "societal concept" requires marketers to act in a socially responsible manner in order to be successful. For firms that wish to adopt the societal concept as an integral part of their business philosophy, it will be noted that profit continues to be essential and basic to corporate survival but the major challenge to business is simultaneously to meet the varying societal needs of a changing environment. Indeed Stanton Etzel and Walker (1991 : 9) assert that "the marketing concept and a

company's societal responsibility can be quite compatible. The key to compatibility lies in extending the breadth and time dimensions of the marketing concept." This could result in the evolution of a societal marketing orientation.

Greater competitive advantages could ensue as a result of the adoption of the societal-marketing concept. Nevertheless the issue of whether or not social responsibility ought to be part of a firm's philosophy is still being debated. It is possible that society's views may well be the deciding factor in the end.

Moreover society's views of corporate social responsibility have changed over time and have reached new and unprecedented dimensions. For those organizations which subscribe to a social responsibility philosophy, much planning and organizing is needed to ensure success. In addition periodic audits must be undertaken to measure the gap between the relevant objectives and actual social performance. Business apathy, resistance or lip service to the marketing and perhaps also to the societal concepts merely increases the probability of direct government intervention by regula-

tion. Such regulation, although intended to be in the interests of consumers, might impose onerous and costly "red tape" burdens on both producers and consumers.

It is posited that if all the "rights of the consumer" were addressed by marketers; the marketing and societal concepts would to a great extent be fulfilled. So called "rights of the consumer" have crystallized in recent times and will be more fully discussed later in this study. It seems however, that consumers believe that their rights are violated so frequently that there is a need for organized consumer action.

2.7 THE GOALS OF CONSUMERISM

Organized consumer action lies at the heart of consumerism and the setting of goals is a key function. However, no single consumer body in any particular country has emerged to protect consumer interests at large because issues generally arise in a random manner and elicit varying degrees of interest from different consumers. Nonetheless

there is at best one goal which is common to all consumer movements and that is to improve the welfare of buyers of goods and services.

Flowing from this central objective, Day and Aaker (1970 : 13; SACCC Policy Document 1989:2; Stanton et al. 1991:612; Kotler and Armstrong 1990:604) submit that there are three broad facets which are representative of the current thrust of consumer movements:-

Protection against clear-cut abuses, which include fraud and deceit, as well as the dangers to health and safety from the voluntary use of products. Day and Aaker note that there is "substantial agreement in principle between business and consumer spokesmen that such abuses must be prevented, but there is often a wide divergence of opinion on the extent of the problem". Consequently the government has intervened by promulgating legislation in the interests of consumer safety. Firms might, however pre-empt government intervention by effectively formulating and implementing industry self-regulation in the interests of all the participants in the market place;

Provision of adequate information in order that the consumer's economic interests are maximized. It is submitted that much controversy and confusion revolve around the issue of whether or not the right to information should go beyond the right not to be deceived, and to include the provision of performance information that ensures a wise purchase.

The question of who should provide the information, has also not been adequately addressed, i.e. should the information be provided by the manufacturer or by impartial sources such as product testing bureau. In some countries independent consumer organizations assume the responsibility of testing products and providing relevant information on products. The purchase and use of the product is then left to the discretion of individual consumers.

The protection of consumers against themselves and other consumers. There is a "growing acceptance of the position that paternalism is a legitimate policy" in consumerism. Day and Aaker argue that "there is a sound basis in economic theory for intervention, whenever the action of a buyer serves only his own best interest and fails to take into

account the effects on others". In this regard the "social responsibility" of the consumer needs to be addressed as well. Although the inculcation of socially and environmentally responsible attitudes among consumers is progressing remarkably in some countries, there are still delicate matters that present challenges to concerned individuals e.g. the protection of unsuspecting consumers from the misuse and abuse of potentially harmful products by other consumers (e.g. accident victims of alcohol and drug abusers).

In achieving these and other goals of consumerism, Hermann (1970 : 57) submitted that it is possible to identify three categories of consumer activists with differing orientations. These three types of activists may still be found in the modern consumer movements of today:-

* The Adaptionists, whose emphasis is on educating the consumer to avoid fraud and deception and to participate intelligently in the marketplace. This group includes consumer specialists and consumer educators who see little need for new consumer protection legislation;

* The Protectionists whose emphasis is on health and safety issues and consists of scientists, nutritionists and other professionals; and
* The Reformers who emphasize the issues of both the adaptionists and the protectionists and who also seek to increase the consumer's voice in the government. This group includes political liberals and what have become known as consumer advocates.

Consumer advocates are self-appointed vigilantes of the business environment. Their roles extend beyond the exposure of malpractices to active representation in courts and government agencies. Consumers, especially in America, have been ably represented by advocates such as Ralph Nader, Upton Sinclair, Mary Philips, Esther Peterson and Rachel Carsons, who are able to identify and publicize problems and implement workable programmes for improvement.

Notwithstanding the differences in approach and the diver sity of problems addressed by each group, it is clear that "consumerism expresses itself in efforts to bring pressure on business firms as well as government to correct business conduct" [Cravens and Hills 1970 : 21].

It may also be noted that consumer organizations have focused attention predominantly on businesses, suggesting that the major responsibility for dealing with consumer issues rests with them. However the responsibility is in fact tripartite, that is, it ought to be shared among consumers, businesses and government, so that workable policies and programmes may be formulated and implemented with inputs from all three interested parties. In this regard, some guidelines for corporate policy formulation have been suggested by some authors, in an attempt to forestall additional government intervention and to elicit customer support.

2.8 CORPORATE POLICY GUIDELINES

Several authors [Buskirk and Rothe 1970 ; Adler 1970; Cravens and Hills 1970; Yohalem 1972; Stanton Etzel and Walker 1991; Kotler and Armstrong 1991], have suggested several guidelines that may be adopted by marketers who wish to compete in an economic environment that is not fraught with standardization and bureaucracy. They have identified certain aspects which they believe need reassessment: viz,

* Corporate Strategy Formulation. In charting the course of the enterprise management must include an assessment of the nature and importance of relevant environmental forces and consider suitable responses since corporate strategies impact directly on overall marketing strategies. More specifically a consumer affairs department, that is properly integrated with other functional departments, needs to be established to advise management in this regard;

* Marketing Intelligence. The responsibility for identifying, measuring, interpreting and reporting on events within society at large is undertaken within the marketing intelligence function. Marketers need to become cognizant of new environmental scanning methods, with particular emphasis on qualitative and psychological research methods; since assessing and understanding customer attitudes and preferences may provide marketers with the ability to more effectively participate in public policy issues associated with the consumer movement. Although some marketers have allocated substantial resources to conduct research into customer attitudes and preferences, few have enjoyed

the benefits of a coordinated and integrated programme because of the fragmented manner in which such research programmes are conducted among consumers;

* The Establishment of Standards. Marketers need to review product and service quality standards. Such standards should emerge from efficient, logical and democratically representative procedures. Consistent standards tend to increase the effectiveness of honest competitors, and may also be used as effective tools in promotion, production and cost efficiency.

* Development of New Products and Services. It becomes imperative for marketers to audit their current and proposed line of products and services in order to include attributes desired by consumers, while recognising at the same time, the needs of the community in which it conducts its business. Such sensitive marketers are likely to be assured of their long term viability. There are other areas as well, that present social and environmental challenges for marketers, such as environmental development, solid waste management,

improvements in public transportation (i.e reduction of the emission of noxious fumes), thermal pollution and noise control;

* The Firm's Promotional Efforts. Marketers must appreciate the fact that consumers loathe hypocrisy and dishonesty. Consequently, they need to adopt a new approach of truthfulness in their communications function. As soon as marketers recognize a gap between consumers' expectations and product performance, they need to initiate programmes to facilitate the flow of information from the firm to the consumer, while correcting the imbalance.

* The Corporate Operating Budget. The increased costs of consumer oriented marketing efforts need to be incorporated into the corporate operating budget, since a lack of financial resources hampers the effectiveness of the firm's mission. If such costs render the business no longer viable the entire corporate strategy will need revision.

Should businesses continue to adopt the traditional complacent or negative attitudes towards consumers, an inevitable stifling of economic processes would result through a coalition of consumer forces and government intervention. Thus it is imperative for firms, whether they are progressive or defensive, to monitor the consumer environment and to respond imaginatively to consumer demands in order to ensure that the best interests of all the participants are served. Indeed, Yohalem (1972 : 754) points out that

> "So long as the business community retains any appearance of ignoring the revolution in consumer values, the consumerism train will gain speed, trip another series of political signals and the consequences may tangle our economic tracks to the satisfaction of no-one".

Consumerism is evidently a force to be reckoned with, even though the fervour of consumer movements varies at different times over different issues. Indeed some authors (Stanton et.al. 1991 : 613; Kotler and Armstrong 1991 : 606) believe that consumerism in the 1990's will focus on health, safety,

social and environmental issues. This sporadic manifestation of consumerism has prompted some authors to view it as a "product" with a life cycle.

2.9 THE PRODUCT LIFE CYCLE CONCEPT OF CONSUMERISM

Bloom and Greyser (1981 : 51) in their explanation of consumerism, view it as a product with a distinctive life cycle, which they add is consistent with opinions in both the sociology and the political science literature about the evolution of social movements. In addition, they view many organizations, institutions and individuals (in the USA at least) as offering a wide variety of brands of consumerism to different segments of society. They view those brands as products competing with one another for funds, workers, media attention and public opinion, just as businesses compete for capital, managerial talent, retailer support and customer loyalty. The future of consumerism is dependent upon how this "product" adapts to changes in the various sub-systems within a particular society. It may be argued though that such a fragmented approach cannot present a cohesive countervailing force against the whole spectrum of perceived injustices.

Bloom and Greyser (1981 : 52) have speculated that the consumer movement in the USA is in the mature stage. They do however, recognize the fact that renewed periods of growth may occur in the mature phase of consumerism in societies where new waves of discontent or frustration fuel the consumer movement and unleash unprecedented fervour among the participants. On the other hand, worldwide consumer movements reflect varying degrees of recognition and maturation.

2.10 CONSUMER MOVEMENTS WORLDWIDE

Consumerism in different countries of the world has progressed at varying rates. It has grown rapidly in advanced nations that have educated consumers, adequate government inspection services and stringent quality control tests.

Consumer protection in Europe, for example, bears a remarkable resemblance to that within the USA. Furthermore, the idea of product testing which originated in the USA, was adopted in Britain after World War II. Product testing was

also adopted in the Netherlands, Belgium, the Scandinavian countries, Austria, West Germany and France, as well as Australia and Japan. South Africa, too, has adopted the idea of product testing. The South African Bureau of Standards, (SABS) has assumed the greatest responsibility in this regard.

Moreover, President Kennedy's consumer charter [in Lancaster and Massingham 1988 : 282] which recognized the right to safety, the right to choose, the right to be heard and the right to be informed, became widely accepted in Europe and has often been used as the moral and political foundation of consumer protection. Indeed these rights are also included in a set of general guidelines for consumer protection, that was unanimously adopted by the General Assembly of the United Nations in April 1985. The guidelines represented

> "an initial attempt to create an international framework within which national consumer protection policies and measures can be worked out. They are also intended to assist the international community in its consideration of the question of consumer protection policy and to further international co-operation in the the field " (Harland 1987:246).

Initially criticisms were made that

> "the United Nations was 'involving itself in matters which are essentially within the jurisdiction of states and that the United Nations should focus on its basic role of peace-keeper."

However, it was subsequently acknowledged that consumer policy issues are no longer of purely local concern, and that it also fell within the ambit of the United Nation's additional role of "achieving international co-operation in solving problems of an economic, social, cultural or humanitarian character " (Harland 1987:247).

Moreover, international co-operation with regard to consumer protection is needed because of the interdependence of countries and the adoption of international dimensions of many business practices.

The adoption of the United Nation's Guidelines was welcomed by the International Organisation of Consumers Union.

2.10.1. The International Organisation of Consumers Union

The International Organization of Consumers Unions (IOCU) was lauched at a conference in The Hague, in 1960. The IOCU stimulated the interchange of test results and educational material among its affiliates. It has encouraged its members to persuade their governments to implement the UN guidelines, since it views these guidelines as a solid foundation on which demands for better consumer protection can be based. However, the IOCU has experienced problems in countries that have relatively low levels of business ethics and consumer competence, since the poor and illiterate are deprived of even basic protection against dishonest weights and measures, misrepresentation and adulteration of products.

Nevertheless the IOCU noted that consumer movements in well developed countries such as Canada, Britain, Australia, the USA as well as some countries in Europe, were involved with a wide variety of issues, at different times. In an attempt to secure conformity and create greater awareness of press-

ing consumer issues worldwide, the IOCU adopted certain resolutions at its recent world congress in Hong Kong in July 1991. Some of the more salient resolutions were:-

"* to call on all consumers to value the intrinsic worth and diversity of natue, and to protect, promote, and support lifestyles that enrich both cultural diversity and moderation of wants based on ecologically sustainable principles of growth and development.

* to urge governments, international bodies and agencies to take account of consumers' needs in the application of information technologies and to involve and support consumer groups in these activities.

* to step up international lobbying of the United Nations and other appropriate bodies to increase their commitment to consumer education.

* to encourage the introduction of appropriate legislation by governments and to advise consumer groups on legal issues associated with consumer protection "

(S.A. Consumer Third Quarter 1991:3).

The IOCU concedes, however, that governments cannot provide total protection for consumers. Consumers can contribute towards their own welfare by recognising that it is the duty of each individual to behave responsibly in the market place.

2.11 CONCLUSION

Despite the rapid growth of the consumer movement in advanced nations, consumerism nevertheless lacks unified philosopies and policies of action. However, separate groups, each with its own particular concerns sometimes form temporary alliances on certain issues to provide a greater momentum for consumerism.

It may also be seen that consumerism has failed in many countries, to consolidate its efforts into a countervailing force which is effectively able to oppose big businesses. The main reasons are that consumers are difficult to organize and represent because of the diversity of their

interests. Reliance upon the United Nation's guidelines on consumer protection could facilitate the resolution of consumer policy issues.

Consumerism in South Africa too, has encountered similar problems. It will become evident, in the next chapter, that mass discontent and public support for social change did not until fairly recently, produce an active consumer movement in South Africa. It may also be argued, upon reflection of the situation, that the relatively feeble efforts of consumer movements in South Africa resulted from a lack of consumerist oriented political vote seekers and independent vigilantes such as Ralph Nader who have the capacity to mobilize resources and supporters in an attempt to inject vitality into the movement.

CHAPTER 3

CONSUMERISM IN SOUTH AFRICA

3.1 INTRODUCTION

Consumer awareness in South Africa is growing at an increasing rate. Consumers are beginning to realise the importance of an equal bargaining opportunity in the marketplace!

The South African consumer, has until fairly recently, regarded himself as a defenceless victim of entrepreneurial manipulation and exploitation. It will shortly be shown, however, that the gradual emergence of various consumer-orientated organisations have contributed substantially to an improvement in the consumer's position.

3.2 THE DEVELOPMENT OF CONSUMERISM IN SOUTH AFRICA

Consumer activism in South Africa began at the turn of this century with the establishment of the Women's Institute of Natal, Zululand and East Griqualand. Other organizations developed later, such as the Suid-Afrikaanse Vrouefederasie

(1915), the South African Homecrafts Association (1930) and the Housewives League (1935) (du Plessis, Rousseau & Blem 1990:294). These organizations were initially aimed at helping women to become better housewives, which included a continuing appraisal of their effectiveness as spenders of the household budget. Consumer issues were however seen to be incidental rather than central to the functioning of these organisations.

It was not until 1951, that a number of consumer associations as such were formed. They sought to give voice to consumer grievances in an organised and concerted manner. Eleven of these consumer associations soon joined forces to form the "Federation of Consumer Associations". (SACCC Annual Report 1980-81:7).

For a while the Federation flourished, but apathy soon set in. By 1957 it had become apparent to all concerned that the Federation was not strong enough to be an effective representative of all consumers.

In 1961, women from 26 voluntary organizations in the country, came together to form an umbrella body, today called the South African National Consumer Union.

The SA National Consumer Union is an independent voluntary body that represents consumers and "assists them by making them more aware of their bargaining power, rights and responsibilities". The Union, inter alia, acts as mediator between the consumer, commerce and industry, and agriculture; it investigates consumers' complaints and holds conferences on consumer issues. Rousseau (1990:298) believes that it has also contributed to the establishment of more than forty acts aimed at protecting the consumer.

However, the affiliation fee paid by constituent bodies and associate members was insufficient to employ professionals and it became increasingly difficult to carry out the necessary work on a voluntary basis.

In 1971 the Consumer Union approached the government with a request for the creation and funding of a viable consumer body. The government then recognised the need for, and

agreed to finance the SA Co-ordinating Consumer Council (SACCC). After negotiations with the then Minister of Finance, the Council was formally constituted, initially with seven councillors. The number has since then, been increased periodically and it now has 16 councillors (SACCC Annual Report 1990-91:5).

3.3 THE S.A. CO-ORDINATING COUNCIL

The S.A. Coordinating Consumer Council (SACCC) is a State-instituted and State-subsidised organisation which functions autonomously according to the terms of its constitution.

The Council has several clearly defined functions embodied in its constitution (Appendix A) as follows:

* A co-ordinating function, which involves co-ordinating consumer interests, consumer-oriented institutions and campaigns, as well as mediating between consumers and business;

* A representative function which involves representing consumer action, setting up contact with consumers and acting as spokesman;

* An educational or informational function, where educational programmes are conducted at schools, colleges and consumer -oriented organizations; where brochures, guides and pamphlets are issued to consumers to guide them in their purchasing decisions, and to inform them, inter alia, about hire-purchase agreements, contracts and guarartees. In its attempts to foster consumer awareness, the Council distributes its quarterly publication, the "SA Consumer" free of charge, to subscribers (Cronje 1990:96);

* A research and investigative function, aimed at gauging consumer attitudes and preferences, and investigating situations that are allegedly suspicious, exploitative or manipulative. It must be pointed out that the policy of the Council "is one of consultation before confrontation." (Rousseau 1990:297);

* A protective function which is aimed at protecting consumers against exploitation, malpractices, misleading information, dangerous products, and injudicious consumption behaviour with regard to drugs, alcohol and cigarettes.

The Council furthermore studies legislation affecting the consumer; strives for the amendment of legislation, where it is deemed necessary, and advocates the promulgation of legislation in the consumer's interests. The Council has also recently been successful in securing links with other countries in Southern Africa as well as abroad.

In this regard, the Director of the Consumer Council, Mr Jan Cronje represented South Africa for the first time, at the 13th world congress of the International Organisation of Consumer Unions (IOCU) in Hong Kong in July 1991. Significant prospects for South African consumers resulted from this congress. Cronje (S.A. Consumer Third Quarter 1991:3) reported that

"Several African member countries of the IOCU are keen to form a consumer liaison group for the continent and have said that South Africa must be included. Delegates from other countries as well have undertaken to explore ways and means of co-operating with and assisting local consumer bodies."

Soon after the congress, the Consumer Council invited representatives of other countries with a view to an exchange of meaningful ideas.

In response to this invitation, Dr John Beishon, the chief executive of the Consumers Association of the United Kingdom (and an executive member of the IOCU), visited South Africa in September 1991. The Consumers Association (one of the largest private consumers' organisations in the world) indicated that it is seeking active co-operation with South African consumer bodies (SA Consumer Third Quarter 1991:24).

Such co-operation will augur well for local consumer bodies which can draw on the experience and knowledge of the Consumers Association, in providing assistance to South African consumers.

Although consumer awareness is still not at an ideal level, the rate of awareness is increasing at a phenomenal rate. This is reflected in an astronomical increase in complaints received by the Council. The Consumer Council (S.A. Consumer Third Quarter 1991:20) views the telephone as an important means by which consumers can air their grievances:-

* The total number of calls in 1990 was 30 256 while the total exceeded 19 000 for the first six months of 1991.

* Written complaints which totalled 9 202 in 1990 had exceeded 6 400 for the first six months of 1991.

* Several complaints have also been referred to the Council by legal firms.

In response to some of these complaints, the Council assisted in the recovery of goods to the value of R2.7 million in 1990, while the amount of R2 million was surpassed during the first six months of 1991.

Evidently consumers have only recently begun to realise that

> "they are on the losing side due to their lassitude and uninvolvement." (Cronje : 1990-91:4).

Cronje (1990-91:4) also believes that the

> "consumers challenge lies in sustaining and helping himself/herself, and insisting on his/her rights. The consumers' only solution is unanimous, innovative and purposeful action".

In carrying out its functions, the Council (SACCC Policy Document 1989, 20 September : 19) endorses the consumer rights enunciated by President J F Kennedy in 1962 which are specified below.

3.3.1. Rights of the Consumer

* The right to safety:- to be protected against the marketing of dangerous products, and to be assured that products purchased will be safe when used in their intended manner.

* The right to be informed:- to be protected against fraudulent, inadequate and misleading information, false advertising and warranties, deceptive packaging, manipulative selling techniques, unfair pricing and credit terms, and to be given the facts needed to make an informed choice.

* The right to choose:- to be protected against a confusing assortment of products, brands, and package sizes, against collusion among business firms, against monopolies, and to be assured of satisfactory quality and service at fair prices.

* The right to be heard:- to be protected against business firms that are unresponsive to consumer grievances and to be assured that consumer interests will receive full and sympathetic consideration from business, and other channels, such as the consumer organisations, or small claims courts.

The following rights, although not included in President Kennedy's Bill of Consumer Rights are also endorsed by the Council.

* The right to consumer education:- to be educated by marketers as well as the government, the SA Co-Ordinating Consumer Council, and by concerned independent organizations. In its attempt to further consumer education, the Council initiated the establishment of the Consumer Education Trust which was founded in February 1991 (SACCC Annual Report 1990-91:1). The express purpose of this trust is to:
    * improve relations between the business sector and the consumer;

* educate consumers about their rights and responsibilities;
* stimulate effective dissemination of information;
* promote the advantages of an economic system based on market principles; and
* engage in consumer-related research.

* The right to redress:- to be reimbursed or compensated for wrongs suffered, through legal processes or through representation to consumer organisations.

Rights are invariably accompanied by responsibilities, and in order to view the consumer's position in its entirety, an appreciation of their concomitant responsibilities is necessary. This should facilitate a balanced viewpoint of the parameters within which the S.A. Coordinating Consumer Council must function in South Africa.

3.3.2 Responsibilities of the Consumer

Rights claimed by consumers can be legitimate only if

reciprocal responsibilities are acknowledged. The author suggests that it would be logical to expect that at least the following responsibilities should be acknowledged:

* to express wants and needs to marketers in the form of unsolicited letters, responses to marketing research questionnaires or through other methods of communication available to them;
* to search for and to use information that can facilitate price, quality and service comparisons;
* to reduce purchases of potentially harmful products, such as cigarettes, drugs and alcohol.
* to seek remedies or redress promptly when there is dissatisfaction with purchases or upon the delivery of services;
* to be as fair to business, as they expect business to be to them;
* to appreciate the reality of dwindling natural resources and the need for judicious use of such resources;
* to use products strictly according to the instructions provided by suppliers; and

* to make market choices which maximize the satisfaction of personal or family needs.

Flowing from this, a set of rights and the reciprocal responsibilities are encapsulated in Table 3.1.

TABLE 3.1 : RIGHTS AND RESPONSIBILITIES APPLICABLE TO CONSUMERS

RIGHTS	RESPONSIBILITIES
1. To choose	to seek out information and to make discriminating choices so that one maximizes one's need satisfaction. The exercise of this right incudes an evaluation of personal, family and societal objectives as well (e.g. by not becoming a burden to society by purchasing harmful products that contribute to the ill-health of the user or those around him, such as tobacco).
2. to be informed	to utilize information intelligently and to determine the true meaning of the information. To inform one's family as well, about such information relating to the products or services to be used in the home or by family members.
3. to be heard	to make individual and family needs known to marketers through appropriate channels and to communicate dissatisfactions regarding products and\or services to market participants, failing which, consumer organizations may be approached.

4.	to safety	to acquaint oneself with the possible risks of potentially harmful products and services and to act in one's own best interest, as well as the interest of others, where they would be affected. To use potentially harmful products, if they must be used, with due care,and according to instructions of the manufacturer\ seller
5.	to consumer education	to become conversant with educational and legal programmes issued by government departments, consumer organizations, marketers, consumer advocates or others concerned about the welfare of consumers at large. To inculcate in one's family members (children), the benefits of becoming conversant with such programmes.
6.	to redress	to actively seek remedies from the party who is the cause of the grievance. Private action may involve contacting the defaulting party with a view to seeking redress or warning others about the firm or product. Public action may take the form of complaints to business agencies, private or government agencies or the news media.

3.4 THE ROLE OF OTHER CONSUMER-ORIENTED ORGANISATIONS

Apart from the S.A. Co-Ordinating Council and the South African National Consumer Union, there are other government and private bodies which strive to protect and further the interests of consumers. These include the Department of Commerce, Trade and Tourism, the South African Bureau of Standards (SABS) which is entrusted with product testing, the Advertising Standards Authority, a self regulatory and voluntary body, the National Black Consumer's Union, the Housewives League as well as various newspaper groups. The most recent independent consumer body, VATWATCH, has been launched under the chairmanship of Prof L. Tager, of the Law Review Project. Vatwatch comprises 10 members who represent consumer and community groups. The main objective of Vatwatch is to educate consumers about how the Value Added Tax (VAT) system operates. Vatwatch also encourages consumers to report on suspected VAT abuses. (S.A. Consumer Third Quarter 1991:35)

Although the mass media and vote-seeking politicians played a significant role in mobilizing consumerism in Britain and the USA, their involvement has until fairly recently, been limited in South Africa. As a result, South African consumer interest groups and organizations have been established at a slower rate than those in Britain and the USA.

In the past few years, however, South African newspapers have played a major role in generating and sustaining public interest in and awareness of consumer-related issues. Consumer journalism has carved a niche in South Africa, as may be evidenced by the establishment of Action Lines by some newspapers. Consumers are encouraged to report to Action Lines, on any problems they encounter in the purchase or use of products and services. In response, a consumer journalist will investigate, seek redress where applicable and publish the results. The audio and visual media, that is, radio and television are also now devoting more time to consumer issues. Such programmes appeal to consumers of all races and accordingly, the potential impact on the marketplace is considerable, given the generally recognised potency of these media.

3.5 MULTIPLICITY OF CONSUMER BODIES

Although there are no generally recognized consumer advocates or activists, of the calibre of the American, Ralph Nader, in South Africa, there are some individuals, associated with consumer bodies, who strive to promote consumerism whenever the opportunity arises. However, it may be argued though that despite the work that has been accomplished by such people and their organizations, the existence of too many consumer bodies, representing different constituencies and using different approaches, causes confusion. This would constrain the overall effectiveness of their efforts.

In 1989 (Daily News 24-8-89:23) the chief executive officer of a large supermarket chain proposed that all existing bodies should be replaced by a single professionally run organization. An amount of R500 000 was made available to fund such a body. It was envisaged as being independent, well-informed, fully representative and professionally staffed.

However, it seems that the envisaged organisation has not yet materialised.

3.6 CONSUMER BOYCOTTS

Organized consumer boycotts have been used from time to time overseas to enforce consumer rights against recalcitrant firms. They may be viewed as potent consumer weapons against commerce and industry. Protracted consumer boycotts may even result in destabilization of the business environment.

Most of the recent consumer boycotts in RSA have, however been politically motivated. For example, after the Boksburg Town Council, which was controlled by the Conservative Party, decided to prolong petty apartheid locally by barring non-Whites from public amenities, black and coloured residents were greatly incensed. Together with representatives of community groups, black traders, trade unions and Black local authorities, they organized a consumer boycott against white-owned stores in Boksburg. The boycott began in November 1988 and lasted until November 1989, when the central government was able to repeal the underlying laws on which

the Conservative Party had relied. Until then, the appeals of White traders to the Town Council to relent, had fallen on deaf ears.

In March 1989, a Carltonville consumer boycott was also initiated in response to the reintroduction of petty apartheid policies. The boycott ended in September 1989 after the Supreme Court overruled the Town Council's policies of petty apartheid. The court action was brought by White traders who faced ruin as a result of the boycott.

The leaders of these consumer boycotts believed that their actions would impact directly on the respective Council's revenues. However, researchers of the South African Institute of Race Relations found that only a protracted withdrawal of buying power was likely to affect the council's financial position since most funding was collected from industry rather than from retailers. The markets of locally based industries were mostly nation wide or even international and accordingly they were relatively unaffected by the boycotts. (Witness 30\6\89 p.3)

The chairman of the Boksburg Chamber of Commerce and Industry, reported that surveys in December 1989 had shown that "there was a drop in sales which ranged from 15%-90% in different sectors, since Blacks accounted for 50% of the town's usual purchasing power. Moreover, the boycott led to an erosion of business confidence which resulted in the cancellation of major development projects in Boksburg" (SAIRR 1989:380).

The Carltonville Chamber of Commerce also reported turnover losses of between 10%-100%, and many stores went out of business. Similar situations have persisted in other parts of the country as well, to the detriment of local retailers (Daily News 17/9/91:3).

Elsewhere in South Africa consumer boycotts have been instigated by trade unions against stores which refused to accede to what were considered to be legitimate employee demands. The nationwide boycott of O.K. Bazaar's stores as a result of wage disputes in 1990 is a case in point.

O.K. Bazaars as well as other stores which are heavily reliant on black shoppers, have become increasingly vulnerable to consumer boycotts which are sometimes precipitated by events over which they have no control. The SACCC is of the opinion that politically motivated consumers boycotts

> "create a warped image of the consumer as a militant citizen who is not prepared to negotiate" (Weyers : SACCC Annual Report 1990-91:2),

Nevertheless, consumers now realise how much power they have in concerted action in the market place. Accordingly, it is probable that once the potential situation in South Africa has stabilised, consumer boycotts might well continue to be used to address more specific consumer issues, as is the case overseas. Social responsibility issues which can easily be linked to political issues are however, likely to remain high on the agenda.

3.7 LEGAL OR QUASI-LEGAL PROTECTION OF THE CONSUMER

In addition to private individuals and organisations that strive to protect the interests of the consumer, there is a considerable amount of legislation which is designed to protect the consumer.

Self regulatory codes of practice have also been adopted by many industries, such as the Grocery Manufacturer's Association, the Insurance Broker's Association, the Motor Industries Federation, Furniture Traders Association and the Direct Mail Association. (Rousseau 1990:299) These codes have been adopted as an endorsement of consumer rights and in order to promote the long term interests of industry members. It is no doubt preferable for an industry to discipline its own members than to invite state intervention and "overcontrol" through further onerous legislative provisions.

Some of the more important statutes which already exist to protect the consumer are listed in table 3.2.

TABLE 3.2 LEGISLATION PROTECTING CONSUMERS IN SOUTH AFRICA

ACTS AND AMENDMENTS	PURPOSE AND PROVISION
Trade Practices Act 76 of 1976. As amended and finally repealed and replaced by Harmful Business Practices Act 71 of 1988.	Provided for the protection of the relationship between business and consumers.
The Harmful Business Practices Act 71 of 1988	Established a system of administrative control backed by powerful criminal sanctions, which is aimed at giving consumer effective protection from "harmful business practices."
Price Control Act 25 of 1964 as amended by Price Control Amendment Act 16 of 1984.	To control abuses of bargaining power and to fix maximum prices at which goods may be sold.
Credit Agreements Act 75 of 1980 as amended by Act 53 of 1987	Provides for the regulation of certain financial transactions in terms of which movable goods are purchased or leased on instalment credit.
The Liquor Act 31 of 1988	Limits the freedom of persons to sell liquor in South Africa.
Dairy Industry Act 30 of 1961 as amended by Dairy Industry Laws Amendment Act, 32 of 1976	Prohibits particularly the sale of dairy produce that has been condemned as being unfit for consumption by an inspector appointed under the Act.
Animal Slaughter, Meat and Animal Products Hygiene Act 87 of 1967 as amended by Health Act 63 of 1977	Provides for the maintenance of proper standards of hygiene in the slaughtering of animals and the handling of meat and animal products.

Health Act 63 of 1977	Provide for broad ranging measures for the promotion of the health of the inhabitants of the Republic.
Foodstuffs Cosmetic and Disinfectants Act 54 of 1972 as amended by Act 97 of 1986	To control the sale, manufacture and importation of foodstuffs/cosmetics and disinfectants.
Marketing Act 59 of 1968 as amended by Marketing Amendment Act 66 of 1984	To consolidate the laws providing for the regulation of the production and sale of agricultural products. Also provides for the National Marketing Council, which assists in the standardization and grading of agricultural products in the interests of consumers.
Medicines and Related Substances Control Act 101 of 1965 as amended by Medicines and Related Substances Control Act 20 of 1981	Provides for the registration of medicines intended for human and animal use and for the establishment of the Medicines Control Council.
The Small Claims Court Act 61 of 1984	Enables consumers to personally settle claims up to an amount of of R2000, without the assistance of attorneys.

3.8 CONCLUSION

There is a noticeable change in South Africa of consumer attitudes and values, a growing awareness of the individual's rights, as well as the need to rectify the imbalance of power that often exists between buyers and sellers of products and services. The South African media is now playing a vital role in stimulating consumer awareness especially with regard to consumer's rights. However, more attention needs to be focused on consumer responsibilities as well.

The consumer movement has attracted a variety of groups who tend to operate independently. However, greater cooperation and co-ordination is required to create an effective countervailing force against the malpractices and abuses which still exist in the market place.

Although consumerism in South Africa has not reached the same stage of development as it has in the United States of America and Britain, it nevertheless faces similar opportunities and problems. It has the potential to become a significant force in the SA economy.

Firms that disregard the consumer movement, will undoubtedly find themselves at a distinct disadvantage vis-a-vis those who recognize the movement and view it as an opportunity for enlightened marketing effort. It is accordingly appropriate at this point, to consider more specifically what kinds of business responses there have so far been to consumerism in South Africa.

CHAPTER 4

RESPONSES TO CONSUMERISM

4.1 INTRODUCTION

Responses to consumerism have varied over time and now encompass a broad spectrum. In dealing with an increasingly educated consumer, it is imperative that "wider areas of social concerns such as distortions and inequities in the economic environment and the declining quality of the physical and ecological environments" feature prominently in business's attempt to respond favourably and responsibly towards these issues (Day & Aaker 1970:14; Lancaster & Massingham 1988:290).

However, not all firms respond with the same degree of commitment. Indeed, there are many which merely pay lip service to and do not implement reform programmes in the interests of a more enlightened consumer. These firms fail to understand that the nature and scope of consumerism has

the potential to cost industry untold sums of money in actions forced by the government and in lost sales to dissatisfied or militant consumers.

4.2 SPECIFIC RESPONSES TO CONSUMERISM

Studies in the USA in the 1970's revealed that the responses of firms at that time were generally superficial, negative, unplanned and uncoordinated even amongst the largest companies in the country. (Webster, 1973:90). Some of the remarks by marketers were that:-

* "Consumerism has nothing to do with us because we are industrial manufacturers;
* this consumerism is nothing new and anyway it doesn't apply to us because we've always been customer-oriented".

Webster (1973:91) adds that these attitudes overlooked the facts that:-

* new consumerism is rooted in changing consumer goals, attitudes and values; and

* basic changes are occurring in the marketing environment as a result of legislation, more powerful government involvement and the growing legitimacy of consumer advocates.

Accordingly it is suggested that businesses ought to adopt anticipative approaches to consumerism as well, rather than reactive marketing programmes only. This would demand a constant monitoring and understanding of consumer issues and complaints as well as programmes of action that are aimed at consumer satisfaction.

Kotler and Armstrong (1990:609) point out that perceptive business people, realize that the long-run net results from consumerism can be social and economic gains for consumers and marketers alike. Consumerism, when viewed in this manner, could result in fewer unsafe products, more satisfied and healthy consumers as well as more benefits to businesses with respect to unlimited marketing opportunities in:-

* the manufacture and marketing of new products and services to satisfy environmental demands; and
* in reaching the increasingly large segment of environmentally and socially conscious consumers, by adapting their marketing programmes.

Recently, many firms in the USA and elsewhere have actively responded to consumerism by establishing consumer affairs offices. Assael (1984:656) and Fornell & Westbrook (1984:68) submit that by 1984 an estimated 600 US corporations had formed consumer affairs units. Some were created with top management's commitment, while others were created in order to gain a superficial public relations advantage or to present an aura of concern, without any real commitment.

According to Stanton et al (1991:614) consumer affairs departments were formed to:

* deal with consumer complaints and questions;
* represent the consumers' interests when policies and programmes are being formulated; and
* ensure that the firm maintains the necessary degree of societal orientation in its planning.

Consumerism responses can be so varied that they can range from illegal, questionable, and opportunistic practices to adaptive, defensive, regulated or supportive practices, as indicated by Evans and Berman (1982:654) in Table 4.1.

TABLE 4.1 : RANGE OF BUSINESS RESPONSES TO CONSUMER ISSUES

RESPONSE	CHARACTERISTICS
Illegal behaviour	Business practices that violate government statutes, such as price fixing, deceptive advertising, and price discrimination.
Questionable behaviour	Legal business practices that are highly criticized, such as advertising to children.
Opportunistic behaviour	Practices with which a firm capitalizes on the difficulties of a competitor, such as publicizing a product recall.
Adaptive behaviour	Actions after new laws or court rulings.
a) Co-operative	Complete compliance.
b) Non co-operative	Circumvention efforts, such as withdrawing rather than modifying popular, but dangerous, products.
Defensive behaviour	Self-protective actions prior to government mandates.
a) Co-operative	Voluntary improvements, such as unit pricing and nutritional labelling.
b) Non co-operative	Increased conflict with government, such as attacks on federal agencies and lobbying.
Regulated behaviour	Industries operating in heavily regulated environments, such as taxicabs, public utilities, and education.
Supportive behaviour	Voluntary efforts to improve practices taken at the initiative of business, such as labelling toys by the age of children.

Source : Evans and Berman 1982 : 656.

It would be apposite at this point to examine the extent to which these responses have been adopted by South African businesses.

4.3 THE RESPONSE OF SOUTH AFRICAN FIRMS TO CONSUMERISM

Since there is a dearth of secondary information on this aspect an effort was made to collect primary data. A pilot study which was exploratory in nature was conducted during June-July 1988 to determine marketers' attitudes and responses towards consumerism.

Open ended questionnaires (refer Appendix B) were sent through the mail to 54 well known South African marketers.

They were addressed to company officers in senior management positions such as directors, and marketing directors, with a brief message outlining the purpose of the study, viz. to acquire and consolidate information on consumerism as perceived by South African businesses.

The questions were brief and addressed the following issues:

* the firm's concept of consumerism;
* whether consumerism is viewed as an opportunity or threat;
* whether consumerism is perceived as increasing the cost of marketing;
* the existence of consumer departments within the firm;
* the firm's concept of societal responsibility; and
* areas in which the firm assisted consumers and the society in general.

The results from the 26 firms that responded to the questionnaire are indicated in Table 4.2.

Of the 26 firms, 4 were clearly negatively disposed toward consumerism. As regards the remaining 22 sets of responses, several were somewhat ambiguous. Perhaps this was due to an absence of specifically relevant policies, or an absence of commitment by top management. Company response highlights are summarized below:

4.3.1. Business Responses to Consumerism and Social Responsibility in South Africa

Company 1 has a policy of customer satisfaction or money back guarantee within 7 days of purchase of product.

Company 2 does not view consumerism as a threat. Consumer complaints are investigated and responded to, and needs are catered for.

The social responsibilities of company 3 include funds for education of Black and White students, conservation and donations to charities.

Company 4 highlights priorities such as housing, job creation, community development, health and education as corporate social responsibility issues.

Company 5 is committed to social responsibility but did not specify what this entailed.

Company 6 conducts consumer research with regard to price, quality and service, and responds accordingly. It engages in employee development and staff education via formal in-store training as well as university grants to children of employees.

Company 6 conducts a housing awareness campaign and grants pledge loans and assists in building houses for employees. Its commitment to the community is expressed in the form of support for charitable and welfare organisations, relief of disaster victims by granting substantial monetary and material donations, sponsorship of health conferences, cultural organisations and assistance to disabled persons. It also grants a nation-wide discount to all senior citizens on Pensioner's Day, as a gesture of goodwill.

Company 7 views consumerism in a favourable light. It believes that a positive attitude towards consumerism is a competitive advantage.

Company 8 is committed to political, social, educational human resource development and economic upliftment of the community. It also sponsors language programmes in black schools

to improve literacy. This company also funds in-service training programmes for Black teachers. It promotes health and welfare among the Zulu community via the Valley Trust, (a sociomedical-rural-agricultural project); supports conservation of natural resources; assists in housing of its employees, human resource development, provides educational assistance for employees on a part-time basis and grants tertiary educational assistance for children of employees. Their education trust has most of the universities and colleges as beneficiaries. Many charitable organisations also benefit from their donations.

Company 9 claims total commitment from chairman through line and corporate management to shop floor. The Chairman "believes that the fabric of social responsibility is woven completely through a businessman's whole existence." This company won the FMI (Food Marketing Institute, USA), special award for social and corporate responsibility. It has a consumer advice department, grants senior citizens membership of VIP (Very Important Pensioners) Club (in operation in all 13 hypermarkets). It also publishes Nutri Care which is a guide to healthy eating. Its commitment to the community is expressed in the form of charities to health, welfare, family and other or-

ganisations for the underprivileged. Ecological improvement is also one of its vital concepts. This company also assists staff in housing projects by providing subsidies. It also takes an active part in assisting victims of national disasters by granting donations of money, food and clothing. It grants educational bursaries for both staff and the community and was a founder member of the Urban Foundation which is funded by private enterprise, whose aim is to improve the quality of life of all South Africans.

Company 10 indicated that there is no printed material on consumer policy with regard to consumerism since they do not deal with consumers directly. However, they were engaged in many social responsibility projects, such as environmental conservation, housing of employees, and educational grants to students, among others.

Company 11 claimed sensitivity to consumer needs and investigates complaints thoroughly. It maintains high standards and quality control to ensure customer satisfaction. This company contributes generously to the community development fund, which is intended to assist organisations involved in activities such as cripple care, child welfare, education and

health. It is also committed to meeting broader needs of the community and monitors consumer trends in order to adapt timeously to the market.

Company 12 conducts a comprehensive programme to train employees so that they may attend to customers' queries and complaints satisfactorily. Questionnaires are displayed in stores requesting customers to state their views on products and services. It also has liberal exchange policies or money back guarantees, and liaises with consumer bodies via the Housewives League. This company also provides information on care of clothing and judicious shopping. It demonstrated considerable interest in consumer awareness. A copy of their consumer bill of rights was also furnished (Appendix C).

The publication of company 13, namely "Taking Stock" won the 1987 SA Co-Ordinating Consumer Councils' Media Award. Its stores have also introduced the Senior Citizen's Privilege Card which entitles those over 65 years to a 10% discount on goods purchased on Tuesdays and Wednesdays from any store. Liberal exchange policies and money back guarantees are great patronage motives for shoppers.

The philosophy of company 14 is to strive to be flexible and responsive to the wishes, needs and preferences of viewers and listeners. It supplements formal education by presenting programmes on consumer awareness, social responsibility and consumer responsibility towards the environment and the limited natural resources. It informs consumers on health and economic issues as well.

Company 15 believes that its reputation is based on the quality of product, service and consumer relationships. It therefore guarantees satisfaction to the customers or their money is refunded.

Company 16 has a consumer service department. It provides nutritional information on all its products; money back guarantees on all products; maintains contact with all associate members of the Consumer Union and National Black Consumer Union. Its social responsibility programmes include community projects in the educational, medical, agricultural, business, social and welfare sections.

Company 17 has qualified officers to deal with consumer complaints. As early as 1975 it had a campaign entitled "The Consumer Has the Right to Know." This company played a vital role in encouraging and obtaining necessary information for the establishment of the South African Consumer Union which was supported by this company since the Union's inception. It also abides by industry self-regulation.

Company 18 views consumerism as an opportunity but maintains that consumerism increases the cost of marketing through research and development. It sponsors sporting events.

Company 19 regards consumerism as an opportunity for gaining respect and confidence of both readers and advertisers. It investigates complaints and grievances and responds to complainants.

Company 20 views consumerism as a movement promoting and protecting consumer interests. As such it provides an opportunity for the improvement of financial services and products. It submitted that consumerism does impact upon costs of

marketing through research and development. This company is also committed to the improvement of social, educational and environmental issues.

Company 21 submitted that it has its own established services of gathering consumer information for both the company and the industry but that it was not prepared to divulge any further information.

Company 22 views consumerism as an opportunity and works closely with some consumer bodies. It submitted that despite the fact that marketing costs are increased through research, the benefits obtained through improved sales of the product, justify such costs. Its golden rule is that "the consumer is always right and therefore it responds to all complaints".

Company 23 considered the information to be confidential and thus made no further response.

Company 24 indicated that it did not know about consumerism: thus it was not able to assist.

Consumer 25 mentioned that it had no set policy on consumerism but it acts on individual complaints and only grants meal vouchers if a complaint is viewed as being serious.

With regard to company 26 the Managing Director of this popular hotel, casino and country club indicated that this company was not aware of what consumerism entails.

4.4 CONCLUSIONS FROM THE PILOT STUDY

The response rate was 48.1 per cent. Of the 26 firms that responded, 84.6 per cent indicated that they were aware of consumerism and that they had implemented programmes to facilitate the communicative and negotiative processes between consumers and themselves. The fact that 51.9% of firms did not respond to the short and very basic questionnaire on consumerism and societal responsibility, may in itself reflect their shortcomings with regard to consumerist policies.

Although retailers could not generally be considered the representatives of consumers since their profit-seeking goals are often regarded with some reservations, they would nevertheless seem qualified to be "protectors of consumers,

both as catalytic agents to resolve consumer - manufacturer differences and as surrogate advocates to use their purchasing power to influence suppliers". (Rosenberg 1975:37)

It is evident that many respondents viewed consumerism as a phenomenon which is compatible with and which may strengthen retailing, since it is a viable mode of adapting to an ever-changing environment.

Logically, positive responses by marketers to complaints can only be in the best interest of both consumers and marketers in the long term. Moreover, it would curb the promulgation of restrictive legislation which leads to added costs in the form of elaborate record keeping and which is ultimately passed on to the consumer.

It is possible to identify aspects of commitment and innovation in the respondents' philosophies and policies regarding both consumerism and social responsibility. The consumerism - societal-oriented retailer possesses a commitment to serving consumers directly and to working with other interested organisations for the benefit of society at large. Thus, he mo-

bilizes resources to implement programmes in the areas of consumer protection, assistance and education, as may be seen from the responses in Table 4.2

TABLE 4.2 : RANGE OF BUSINESS RESPONSE TO CONSUMERISM AND SOCIAL RESPONSIBILITY IN SOUTH AFRICA

COMPANY/FIRM	POLICY OF CUSTOMER SATISFACTION OR MONEY BACK GUARANTEE	CONSUMERISM NOT A THREAT BUT OPPORTUNITY	CONSUMER COMPLAINTS INVESTIGATED AND RESPONDED TO	FUNDS FOR EDUCATION OF STUDENTS	SPORT	FUNDS FOR CONSERVATION	DONATIONS TO CHARITIES AND DISABLED	HOUSING AND COMMUNITY DEVELOPMENT	FUNDS FOR HEALTH EDUCATION AND IMPROVEMENT	EMPLOYEE DEVELOPMENT AND STAFF EDUCATION	GRANTS AND DISCOUNTS TO SENIOR CITIZENS ASSISTS DISABLED	EXISTENCE OF CONSUMER ADVICE DEPARTMENT	PROVIDES INFORMATION ON PRODUCTS VIA PAMPHLETS	SUBMITTED CONSUMER BILL OF RIGHTS	KEEPS CONTACT WITH CONSUMER GROUPS/BODIES	INCREASE S COST OF RESEARCH AND DEVELOPMENT	HAVE DEGREE OF SOCIAL RESPONSIBILITY BUT DID NOT SPECIFY	INFORMATION CONSIDERED TO BE CONFIDENTIAL & NO FURTHER RESPONSE	DID NOT KNOW WHAT CONSUMERISM IS	NOT ABLE TO ASSIST	NO POLICY ON CONSUMERISM BUT ACTS ONLY ON VERY SERIOUS COM-
RETAILER 1	X	X																			
2		X	X																		
3				X		X	X										X				
4							X	X	X												
RETAILER 5																					
RETAILER 6	X	X	X				X	X	X	X	X										
7		X								X											
8		X		X		X	X	X	X	X											
RETAILER 9	X	X	X	X		X	X	X	X	X	X	X	X								
10				X		X	X	X	X												
11	X	X	X	X			X		X												
RETAILER 12	X	X	X										X	X	X						
RETAILER 13	X										X										
SERVICE 14		X		X		X			X				X								
15	X		X																		
16	X			X			X		X			X	X		X						
17		X	X									X			X						
18		X			X											X					
SERVICE 19		X	X																		
SERVICE 20		X	X	X		X	X					X									
21																	X				
22		X	X												X	X					
WHOLESALER 23																		X			
24																			X	X	
RETAILER 25																					
HOTEL & C. 26																			X		X

On the basis of the material examined, thus far, it is suggested that other marketers attempt to:-

. understand the consumer, and develop programmes to ensure that top management is acquainted with the reality of the consumers situation, and oriented towards this perspective;

. redress grievances and respond to enquiries and suggestions amicably, while viewing this as an information feedback system; and

. mobilize resources so that comprehensive consumer programmes are developed with the aim of disseminating useful and timeous information to the consumer enabling him to be better equipped to make intelligent purchasing decisions.

On the other hand consumer organisations should co-operate with each other and co-ordinate their efforts in order to present a countervailing force against malpractices and abuses that still exist in the marketplace. In responding to consumer demands it may be seen, that marketers are not without options.

The prospect of more stringent and onerous legal regulations, often prompts firms to co-operate with others in an attempt to provide self regulation. If self regulation is to enjoy credibility, it requires the implementation and enforceability of programmes.

4.5 IMPLEMENTATION AND ENFORCEABILITY OF PROGRAMMES

4.5.1 Self Regulation

Self regulation has many advantages, the most important being that it can be more responsive to changing conditions than laws and it may be less expensive to establish and implement.

Companies which recognize consumers' rights, may oppose certain pieces of legislation on the grounds that such measures are not the best solutions to the problems. Indeed, some businesses have adopted the concept of enlightened marketing, where marketing decisions are made not only by considering consumers' current wants and the company's requirements but

also by considering the consumers' long-run interests as well as society's long-run interests (the societal concept in marketing).

Self regulation (as opposed to government regulation) is preferred by businessmen, but consumer advocates feel that efforts at self-regulation have not been successful enough (Koopman 1986:274). In order for self-regulation to be successful, an industry must be able to force its members to comply with industry standards. Koopman (1986:274) also asserts that government prefers self-regulation because it genuinely believes that in a number of instances, self-regulation may produce better outcomes for the consumer than the legislative instrument could accomplish.

Stanton, Etzel & Walker (1991:614) believe that a reasonable solution is some form of industry-government cooperation whereby the industry sets its own standards, and once accepted by the government, the government then enforces these standards.

Finally, the effectiveness of self regulation is limited because:-

* It is difficult to get a consensus among industry members regarding an acceptable set of standards, thus resulting in the setting of the least common denominator as the level for its standards.

* Executives often fail to see anything wrong in various business practices in their industry, even though they are highly criticized by outside observers.

Self regulation needs to be enforceable industry-wide if it is to be meaningful. One of the most common areas of self-regulation is product standards, which may, inter alia, concern safety, size and style variations. However, according to Stern (1975:50)

> "the principal danger of product standards is that they may slow product improvement and innovation or deny reasonable product alternatives to consumers."

In order to protect consumers in the short-run and preserve the long-run benefits of freedom, the answer according to Stern (1975:50) is to:-

* provide maximum consumer involvement in the writing of product standards;

* provide for automatic review of standards at frequent intervals;

* permit collective action among firms to boycott any firm whose products conform to neither industry standards nor labelling requirements.

Another area of self-regulation which is vitally important to consumer welfare is promotional practices. The difficulty of self-regulation with regard to promotional practices is two-fold, viz.

* non-perception, which is a failure to perceive any injustice in questionable practices, and
* non-responsibility, where sellers recognize the wrong but accept no responsibility for it.

Business should ideally aim at generating a much higher confidence level among consumers, bearing in mind that self-regulation can serve as a preemptive force in relation to consumer advocates and governmental action.

4.5.2 Government Regulation

In terms of a resolution adopted by the General Assembly of the United Nations, (At the 106th plenary meeting : 9 April 1985) general guidelines were distributed to governments relating to consumer protection.

It recommends that governments should develop, strengthen or maintain a strong consumer protection policy, while considering the guidelines as set out in the report (Appendix D).

Each government may set its own priorities for the protection of consumers in accordance with the economic and social circumstances of the country, the needs of its people and the costs and benefits of proposed measures. In this regard, the most recent recommendation of the President's Council was that the South African Coordinating Consumer Council be restructured and given legislative support within an expanded Department of Trade, Industry and Consumer Affairs (Daily News 27/11/91:29). It is uncertain though, whether such an arrangement would in fact result in an envisaged improvement of the consumer's position.

The government's task becomes more complex when it has to balance the costs against the benefits to be derived from certain measures. Benefits themselves, being highly individualistic and subjective are often difficult to appraise, thus complicating the problem further.

Consumer protection legislation requires a cost-benefit analysis before implementation. However, it is submitted that it is difficult to obtain agreement on the relevant dimensions of costs and benefits or about the most suitable measuring instruments, thereby casting a certain amount of scepticism on the analysis. On the other hand, badly needed reform may be postponed or prevented by conducting empirical studies on cost-benefit analyses which are usually very time-consuming and of dubious validity.

The subject of government versus self-regulation in consumerism is significant since there are many objections to government regulations, some of which according to Koopman (1986:283) are that:-

* it leads to further and repressive legislation;

* regulations proliferate in order to close loopholes that have been found by businesses;
* there is a lack of uniformity of application, which may be regarded as being unfair; and
* regulatory actions take many years to conclude.

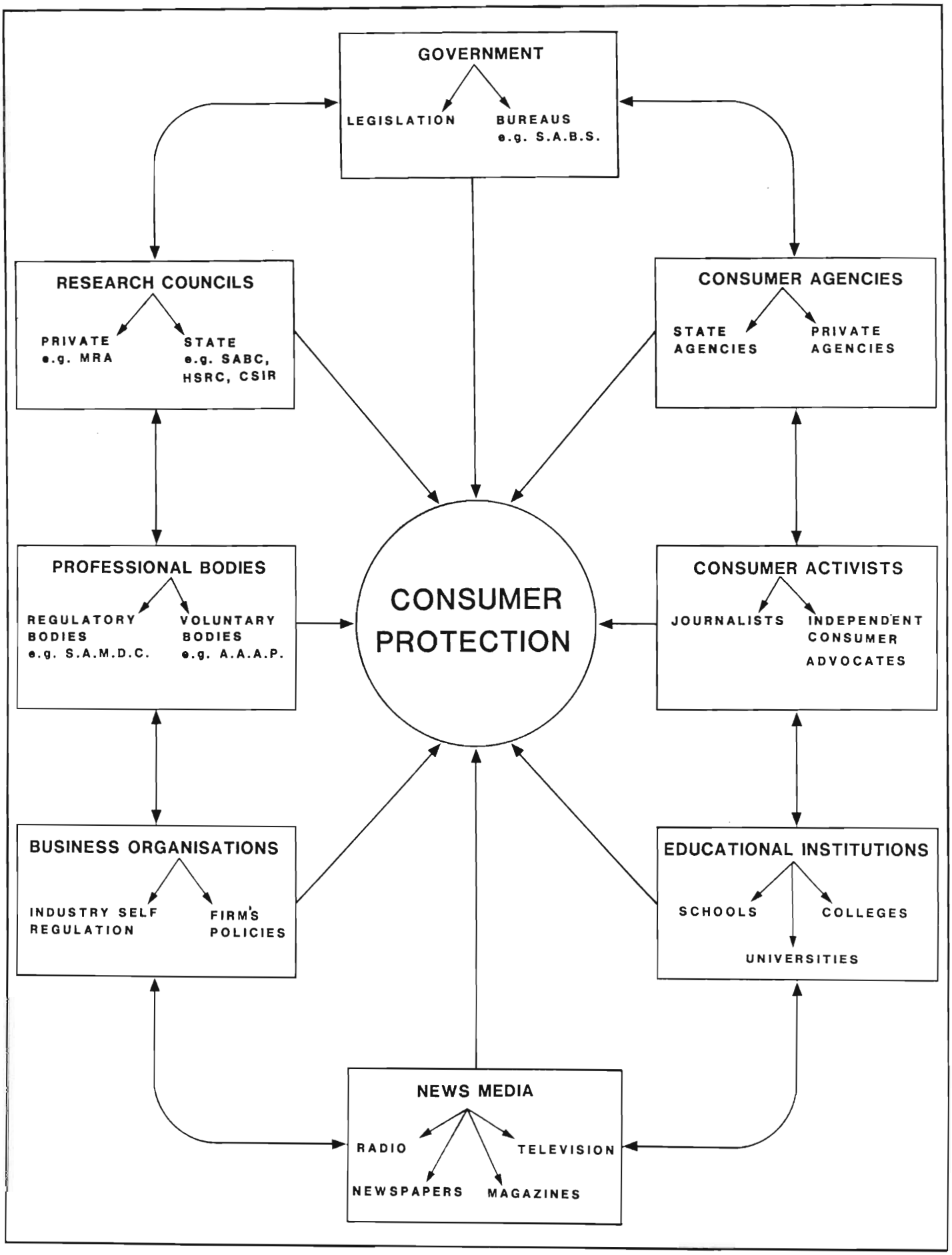
Consumer protection may take many forms and may differ according to the products, services and the prevailing macro-environmental conditions present within a country at a given time. However, a major criticism concerns the higher costs involved, as a result of actions demanded by government. Marketers could stem the flow of government intervention if they adopt a firm commitment to consumerism and social responsibility.

Consumerism, when viewed as a threat, may result in some undesirable consequences such as stifling of initiative; development of cumbersome bureaucratic structures, limited innovation and competition or even misrepresentation of business accomplishments.

In order to deal with consumerism successfully and to ensure protection for the consumer, there should ideally be a meaningful interaction among the various organizations that can

impact upon consumerism by virtue of the influence of such organizations on marketers. The interaction of the protective efforts of state, semi-state, business organisations, consumer journalists and other independent bodies is likely to produce a positive, synergistic effect on consumer protection in general. This protection could effectively pre-empt the promulgation of onerous legislation. A schematic representation of these protective organisations is depicted in Figure 4.1. This schematic representation has been derived from the material presented in the preceding chapters. It encapsulates the idea that optimum consumer protection is a function of the integrated activities of all consumer directed organisations.

FIGURE 4.1 : THE CONSUMER PROTECTION MODEL



4.6 CONCLUSION

The existence of consumerism bears testimony to the failures of marketing, while at the same time it has been responsible for an increasingly important social awareness among marketers, some of whom have responded by implementing valuable programmes.

Although there is consensus among firms, government and consumer organizations, that consumerism is a force to be reckoned with, there are nevertheless, differences in perceptions about the underlying causes and the actions to be taken to protect consumer interests.

These differences in perception significantly impair co-operative efforts among the various sectors. Consequently, the advancement and protection of consumer interests is difficult to achieve. Thus it is necessary to effect a higher degree of communication and co-operation among all the participants in the marketing system.

Consumers too, should sincerely share in the responsibility for preserving an efficient business environment.

Finally, it is suggested that the consumer's interests be more adequately represented at the strategic planning stage, despite the fact that producer interests have predominated at such decision-making levels until now.

In the analysis thus far, attention has been focused on commercial products and services generally. This analysis provides valuable insights into the general application of consumerist issues and should constitute an adequate base from which more specific areas may be viewed and expanded upon. Against this background, the remainder of this study will be devoted specifically to consumerism in the medical sector, which has until recently received scant attention.

Initially the parameters within which private practitioners function, will be outlined. The patients rights and responsibilities will then be identified in order to accommodate the empirical evaluation of a number of hypotheses which will emerge from the text.

CHAPTER 5

5. THE HEALTH CARE SYSTEM IN SOUTH AFRICA

5.1 INTRODUCTION

The health care industry in South Africa is basically a professional service industry. South Africa has a mixture of free enterprise and state financed medical care. Despite the existence of this combination of systems, serious doubts have been raised regarding the equitable nature of health care delivery. It has also become apparent that the existence of apartheid served as a significant obstacle to a well planned and adequately controlled system of health care delivery. Health care delivery was initially divided between "Whites" and "non-Whites" until the inauguration of the tricameral system in 1983 when the fragmented system of health administration caused costly and time-consuming triplication of services. The fragmentation still exists for three "own affairs" ministeries which pertain to the health requirements of Whites, Coloureds and Indians and also among the various independent and self-governing bureaucracies of the African "bantustans".

According to recent analysts, the cost of providing separate facilities alone amounted to more than R800 million per annum. This amount excluded the cost of maintaining 18 health administrations and 14 ministries of health, including deputy ministers and their assistants (Kelly 1988:117).

There is thus a pressing need for the establishment of a unitary health care system, since fragmentation is both wasteful and contrary to ethical codes of medicine. Although South Africa spends about 6% of its G.D.P. on health, this figure conceals wide variations between geographical, social, economic and racial sectors. The state's expenditure on health for 1991/1992 is expected to be 2.7% of the G.D.P. Of this amount, less than 5 percent is devoted to primary health care. Private sector expenditure on the other hand already represents 45% of total health spending (RSA Budget Review 20/3/91).

5.2 THE SYSTEM OF HEALTH CARE DELIVERY IN THE RSA

Among the various problems that South Africa faces, the most appropriate system of delivery of health care, presents a particularly difficult dilemma. Indeed, the present

government's generalized commitment to privatization also extends to the medical services sector. The announcement of that commitment has met with strong reaction and severe criticisms from those who have a genuine interest in the population's health care needs.

Navarro (1982:2) argues that "Privatization is an economical and political strategy for the transfer of certain public activities and responsibilities to the private-sector". While the government espouses this viewpoint in order to reduce its financial burden in respect of health care, some concerned medical professionals and others believe that a healthy life is the democratic right of all South Africans. Consequently, everyone should receive proper treatment and care when sick, old or otherwise unable to look after themselves. It is felt that free medical care and hospitalization should be provided by the State and that the State should initiate and maintain a preventative health scheme for all its citizens.

Benatar (in Lee 1989: 158) points out that this idea is not new. Apparently a plea was made for such a service as long ago as 1931, and that the Gluckman Commission had strongly

recommended the setting up of such a service in 1944. But the system did not materialize. However, the government's present inclination towards privatized health care has resulted in renewed calls, within the context of a highly volatile political climate, for the establishment of a National Health Service (NHS) which is financed and controlled by the government. A NHS will provide citizens with a health care system where they receive adequate care irrespective of their ability to pay, the ultimate aim being to reduce diseases in all sections of the population. Proponents of a NHS believe that health care should not be regarded as a commodity in the capitalistic marketplace, available only to those who can pay for it at exorbitant prices. Another concern of NHS proponents is that of overservicing and overprescribing by overzealous private practitioners whose remuneration is related to these aspects of their service.

5.2.1 Private Medical Care

Privatization, on the other hand, views health care as a commodity and the system of delivery of medicine progresses along the same route as an enterprise. One's ability to pay determines the level of health care one may receive. In ad-

dition it is believed that with the increasing sophistication of practices and procedures and the attempt to recover the cost of highly complex and expensive technology and other facilities from patients, much of the humanism that is so vital to the delivery of health care is bound to disappear, because of the overriding factor of profit maximization. Lee (1989:45) warns practitioners that

> "a clear distinction must be drawn between privatization of medicine and commercialization where this impinges on traditional professional areas of responsibility".

Another vehement critic, Prof Benatar (at the 56th Congress of MASA) said that:

> "Commercialization leads to the dominance of the profit motive and the much vaunted marketplace is random, socially insensitive and exploitative".

Advocates of the "free market solutions" to health care believe that healthcare is a privilege and not a right. Therefore it must be distributed according to the supply and demand forces of the market (Critical Health No. 19 April 1987: 22).

Despite the inherent financial problems of patients in a privatized system, the present status of public health care delivery has compelled patients to consult with private practitioners. Moreover, the government's unwillingness to improve the method of public health care facilities, and the consequent movement to the private sector of those who use medical aid and/or insurance benefits, have contributed to a significant increase in privatized medical care. Private medical care costs are increasing constantly and constitute an ever increasing portion of an individual's personal disposable income. In addition, there appears to be growing discontent among private patients with regard to the service they receive from private medical practitioners. Even a cursory review of the marketplace for medical products and services suggests that there is an imbalance between supplier and consumer as a result of structural inadequacies caused by an asymmetrical power distribution and an inhibited informational interface.

Medical practitioners are professionals, operating within a highly scientific system, while their patients are unfamiliar with the products, methods and procedures involved.

Patients are thus unable to objectively evaluate medical products and services. Accordingly the need arises to restrict untenable practices via professional codes of conduct. Indeed, statutory regulations are enforced to protect the public within the privatized system of medical care. Within this highly regulated system however, it is possible to easily identify market characteristics which have been conventionally applied in the marketing of commercial products. It will shortly be observed that there is an increasing trend toward the adoption of market principles within the private medical care industry. At the same time the providers of these services also enjoy greater monopoly powers than their entrepreneurial counterparts in the commercial sector because of the existence of formidable professional associations and the absence of a countervailing patients' association.

5.3 SUPPLY AND DEMAND CHARACTERISTICS OF PRIVATE PRACTICE IN RSA

An understanding of the theory and role of monopoly and competition in the medical service sector is fragmentary, primarily because the various concepts and philosophies of

competition and monopoly reflect a predominantly goods orientation. Moreover, the medical care system in South Africa is inhibited from following the principles of a fully market oriented economy, even though substantial amounts are paid by private individuals for services received from practitioners. Competition which is of prime importance in other sectors is restricted in the medical service sector, although some competition exists between professional groups: for example, medical doctors versus chiropractors or osteopaths, and optometrists versus opthalmologists.

There is also a lack of vital consumer information which precludes rational purchasing decisions, since health care is highly specialized with intensive use of sophisticated and complicated technology. There is also a lack of effective price competition which often results in increasing prices. It is believed that a lack of competition also conceals information about the most efficient methods, hospitals and doctors. A further factor is that consumers are unable to determine when medical services are needed because of the very unpredictable nature of illness.

At the centre of the medical care system is the medical practitioner, who is involved with the patient from the initial interview to the final discharge. The consumer "surrenders his sovereignty to the doctor who acts as his agent by determining needs by diagnosis and implementing wants by the selection and purchase of available services on behalf of his client" (Crane et al 1974: 181). Thus it is evident that the consumer may exercise choice only in selecting a primary doctor (on the basis of very little information) but his choice is limited in selecting a specialist since this is done through a system of referral by the primary doctor. This professional co-operation with each other through rigidly defined roles serves as a vital co-ordinating mechanism in the medical care sector. The rationale is that specialist's services should be utilised more efficiently with general practitioners attending to less complicated ailments.

Another characteristic which restricts choice further is the fact that demand exceeds supply in the South African marketplace. The balance of supply and demand becomes a critical issue in the provision of medical services. These services require large investments in capital and time in

order to have qualified people to perform them. A compromise in the quality of medical education in order to match the demand, is likely to have serious repercussions. However, a criticism in this regard is that a lack of central policy direction has led South Africa to cater for expensive secondary and tertiary health services at the expense of preventive and primary care, which is desperately needed by the majority of South Africans.[1] It is also believed that South Africa's medical schools, through their specific training procedures, have become highly powered technocratic institutions churning out first world doctors who are not trained to deal with the health needs of the majority of South Africans.

These problems are exacerbated by the emigration of many young highly skilled practitioners who have been educated in South Africa at great expense to the taxpayer. This exodus also has profound implications at the teaching and research levels, which could result in a lowering of standards of health care. It is submitted that the medical student

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1. However, Dr R Venter, Minister of National Health and Population Development, revealed in 1990 that 20 PHC centres were to be established in the RSA.

recruitment process needs to be addressed, since rich, privileged students tend to emigrate when they are faced with a country in conflict or when they merely prefer to move to more lucrative practices in other countries.

However, it is difficult to apply a test of intent, and nothing can be done at the selection level, said Prof Rosendof (Sunday Tribune, 19-7-89:1).

Since the nature of medical services differs from goods in some major respects, this has a significant impact on the nature of monopoly and competition in this industry: for example, market forces are substituted by formal and legal regulations because it is believed that the structural imbalances and the critical nature of medical services necessitate statutory regulations for the protection of the public. Consequently, the South African Medical and Dental Council (SAMDC) was constituted in terms of the Provisions of the Medical and Dental and Supplementary Health Services Professions Act 56 of 1974.

The South African Medical and Dental Council is made up of persons nominated by the Minister of National Health and Population Development, representatives of medical and dental training schools and medical practitioners and dentists elected by colleagues. Every medical practitioner, dentist and member of the Supplementary Health Service Profession is required to register with the SAMDC. Each member is required to pay an annual prescribed fee.

The SAMDC promulgates rules and regulations pertaining to medical training and examinations. It is also responsible for setting standards of ethics and professional conduct.

The SAMDC must approve all training centres, as well as all degrees obtained for the purpose of registration with the Council. The SAMDC is also empowered to investigate misdemeanours allegedly committed by registered members, and it may institute binding punitive or disciplinary measures if members are found guilty of such misconduct. The Supreme Court has ruled that in effect, the SAMDC is the sole repository of power to decide what is improper or disgraceful conduct on the part of a doctor.

Although the courts are reluctant to interfere with an SAMDC decision, the Supreme Court has an inherent power of review of statutory bodies. The Supreme Court may review and correct or set aside decisions of the SAMDC on the ground of procedural irregularities.

Recently, a perturbing situation, was revealed (John Berks Show 2/8/90 at 20h00: Medical Malpractice on M-Net) when the Registrar of the SAMDC acknowledged that not all the decisions taken as a result of inquiries by patients are communicated to the complainant or to the media. This could lead to the belief that a situation could arise where, for example, a complaint is not even investigated at all, since there is no obligation to report the findings of investigations or inquiries. Indeed, the sentiments expressed by victims of medical negligence during the show were, that the SAMDC protects its members to a greater extent than the public in whose interest it was originally constituted to serve. This certainly needs to be probed in the empirical study as well.

Nevertheless, the SAMDC imposes contraints on competition by prohibiting various pricing and promotional practices, such as advertising to the public. The SAMDC regards such activities as being "unethical".

Ease of entry into the market is also limited by regulations requiring registration. Regulations for registration and maximum pricing schedules are believed to be essential in order that these services are not allowed to function within the "chaos of the uncontrolled marketplace", since these services are critical to the welfare of the community. An uncontrolled marketplace in respect of ease of entry, could see a proliferation of quackery which would be disastrous.[2] (Sunday Times 24/3/1991:3).

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2. A forty year old bogus "paediatrician" who had been "practicing medicine" for at least 10 years appeared in court in connection with charges of, inter-alia, culpable homicide, (since 10 children who were treated by him died) impersonating a medical doctor and 4 500 cases of fraud arising from payments by medical aid societies (Sunday Times 24/3/1991: 3).

Thus the necessity for regulations must flow from the need to assure the public or market that minimum standards of performance can be expected, given the inability of the purchaser to examine and evaluate the service in advance. Despite the inability of the purchaser to examine and evaluate the services in advance, there are nevertheless aspects of the marketing mix which may be identified by purchasers within the private medical sector.

5.4 THE MARKETING MIX WITHIN THE PRIVATE MEDICAL SERVICE INDUSTRY

5.4.1 The Product

The "product" in this industry is primarily the "service" responsible for the maintenance of an individual's well-being and even more fundamentally, his continuing existence, as well as some medication which may be dispensed directly by a doctor or by a pharmacist, who is specifically qualified therefor. The medical practitioner is one participant in this transaction, while the patient is the other. Rathmell (1974: 171) describes a patient thus:

"The consumer is a client, not a customer, of the provider of health care. The distinction is profound. A customer takes title to a good upon purchase and the seller has no control over the consumption of the product he can only advise. The client on the other hand, places himself in the hands of the provider or seller". Thus the purchase decision is not a unilateral decision, since what is purchased, is decided upon by the doctor.

Medical services involve simultaneous production and consumption as well as the intimate participation of the buyer in the performance of the service. Services do not have form utility, but they do have some concept of performance utility. The satisfaction of this utility may be high or low depending on the level of professional skill of the provider. The qualitative element in the delivery of service is the overriding factor in determining a measure of their performance productivity.

Fortunately, to assist them, physicans and hospitals have at their disposal various sophisticated instruments which may improve the quality of their performance,provided the doctor maintains an empathetic attitude towards the patient.

Although it is difficult to assess the quality of health care, there is nevertheless a perception of differences in quality among discerning consumers, which may be manifested, inter alia, in the doctors "bed-side-manners", the attitude of his supporting staff towards the patient, easy access to the doctor in emergencies, and/or the diagnostic equipment at his disposal.

If performance were to be measured in terms of the number of visits to the doctor or by the number of days spent in a hospital, then this would be comparable to measuring the output of any product industry without considering quality, durability or performance characteristics of the product. These aspects are becoming increasingly salient in quality assessments by consumers.

Quality assessments may be made, to some extent, in respect of medication that doctors dispense personally. There has been no prohibition against the dispensing of medicines by doctors. However, since December 1984, in terms of Section 52 (2) of the Medical, Dental and Supplementary Health Services Professions Amendment Act, all dispensing doctors are

required to register as such with the SAMDC. There are 4 800 registered dispensing doctors of whom 2 300 are actively dispensing. (Daily News 13/6/90: 4). Other doctors prescribe medication which has to be purchased from the pharmacist who charges a levy for the dispensing of the medication in addition to the amount for the medication. The reason for registration as a dispensing practitioner is so that the SAMDC may be aware of their identities. It may then exercise its extended disciplinary powers where necessary,since doctors are not obliged to adhere to the Pharmacy Act of 1974 which provides for matters relating to the sale of medicines to consumers.

5.4.1.1 Dispensing of Medicines

The dispensing of medicines by medical practitioners remains an area of contention between doctors and pharmacists, who claim that this is the purpose for which they have trained and qualified. On the other hand, the voluntary association of medical practitioners (MASA) as well as the SAMDC recognise the fact that it is the inalienable right of practitioners to dispense medicines for their own patients.

As a result of patient complaints in the 1980's of the inability to meet the high costs of medication at pharmacies, many city doctors began dispensing medication. This caused a furore among the urban pharmacists who felt that they had a formidable competitor in the prescribing doctor (Kobrin 1990:14).

Dispensing doctors are believed by the author to be more attractive to many patients (an extended product line). Dispensing also improves a doctor's financial position because profits are also derived from the sale of medicines by doctors. Some believe though, that "the decision to enter the market as a dispensing practitioner, where readily available pharmaceutical services exist, is based purely on financial gains to the practitioner." (Editorial, SAPJ. 1989 Sept: 314). However, it has been claimed that the total health care bill is less when a dispensing doctor is consulted (Kobrin 1990 : 15).

Undoubtedly, the dispensing doctor serves a vital role in the community especially in areas where pharmacists do not operate. Other benefits that accrue to patients through the use of dispensing doctors are:

* a higher patient compliance with directions for use and dosage;

* convenience to the patient who does not have to locate a pharmacist who is open for business, since business hours differ among different pharmacists;

* reduction in delays in acquiring the medication since many patients do not immediately purchase medications after receiving a script from a doctor; and

* price competition results, which is in the economic interests of the patient, since pharmacists are competing among each other and with the dispensing doctor as well. (Price competition is not prohibited among pharmacists although the advertising of ethicals is prohibited by the Pharmacy Council).

Although some concede that the doctor may legitimately dispense medicines to his (or his partner's) patients, they nevertheless contend that the dispensing of medicines and the diagnosis of diseases require a thorough knowledge in

different and very specialized areas. Some scepticism therefore exists, as to whether the medical practitioner is as intensely aware of pharmacological actions and reactions and the importance of the "quality - chain" of medicines as his pharmacist counterpart who has comprehensively studied pharmacy for no less than four years at an approved university (Editorial, SAPJ. Sept. 1989:314).

The Medicines Control Council and the Department of Health and Population Development in its attempt to maintain product quality and safe storage during the distribution phase of medicines to the final consumer, have performed inspections at dispensing medical practitioner's outlets and found that consumers have received substandard medicines at some outlets. It was found that the standard of "good dispensing practice" was embarrassingly compromised in the case of many dispensing practitioners (SAPJ Sept 1989: 312).

The following irregularities were revealed:

* Unnecessary and/or unsuitable medicines were supplied to patients as a result of irresponsible purchasing of large quantities of medicines from highly persuasive

manufacturer's representatives. Similarily it is said that in the USA, doctors are falling prey to the temptation of dispensing medicines that they have in stock, rather than that which is in the patient's interests, (SAPJ Sept. 1989 : 312).

* Medicines stored under poor conditions and which were consequently "sub-potent" were supplied. Their inspection revealed that 47% of practitioners did not store thermolabile medicines correctly;

* Medicines that had passed their expiry dates had been supplied with grave consequences. It was found that 71% of practitioners did not have a system to monitor expiry dates of their medicines. Moreover, 17% did not even separate expired stock from the rest;

* Cost saving strategies such as using the same disposable syringes and needles on a number of patients had placed a number of patients at risk. The inspection revealed that one practitioner used the same syringe and needle to vaccinate 24 persons of different

population groups against Hepatitis-B! (SAPJ Sept 1989: 313); Hepatitis B is a highly contagious and potentially fatal disease;

* Unregistered, and therefore illegal medicines were found. Medicines for veterinary use were also found in large quantities at medical practitioners offices;

* 26% of practitioners did not keep a record of names and addresses of patients for whom they had dispensed habit-forming drugs, thus making it impossible to control drug abuse or misuse; and

* Almost 50% of practitioners delegated the dispensing of medicines to clerks and receptionists with a very limited knowledge of pharmacy.

In view of these irregularities the Department of National Health and Population Development, through its Sub-Directorate, the Medicines Control Council embarked on a major education programme aimed primarily at introducing the concept of "good dispensing practice" (GDP), to dispensing practitioners.

The Medical Association of South Africa has also embarked on its own educational programme. The South African Medical and Dental Association has also been informed by the Department of its findings.

The conclusion drawn by the Deputy Minister of National Health and Health Services from these findings was that the dispensing practitioner "has committed himself to an activity for which he is ill equipped" and therefore so-called cost savings are negated if the "integrity of the medicine is not preserved and the drugs are not taken correctly".

Being placed in a fiduciary relationship with regard to the patient's interests, and serving as a "proxy consumer' both in terms of the selection and quantity of medicines supplied, it is essential that the dispensing practitioner's own financial considerations should never be allowed to override his clinical discretion and professional ethics" (SAPJ. 1989 Sept 314).

It must however, be pointed out that patients cannot expect guarantees for their purchases of services or products from their practitioners, either in the form of an improvement in their conditions or in the non-recurrence of the condition for which they were treated, they may nevertheless claim for damages caused as a result of negligence on the part of the doctor. The nature of medical care is such that despite the absence of a guarantee for patients, many place implicit trust in their doctors, which ought not to be compromised. This implicit trust has no counterpart in other buyer-seller relationships. Moreover the urgency of medical attention and the limited supply of it, results in an inelastic price sensitivity.

5.4.2 Price

Competitive pricing does not occur in the regulated medical services industry. Maximum prices are authorized by the regulatory body, the SAMDC, and the purchasers of these services have no influence whatsoever.

Prices have always played a passive role in the marketing strategy of the providers of private medical care, because patients do not bargain over prices and do not have a vociferous patient's association which can negotiate on their behalf.

Remonstrations made by the Representative Associations of Medical Schemes have met with little or no success, since medical costs have risen significantly since 1980. Moreover, price differentiation by the doctor is also absent in the case of third party financial intermediaries such as medical aid schemes or medical insurance where a specified schedule of payments is used (usually the maximum amount) irrespective of the financial circumstances of the patient or the shorter time spent in attending to him/her.

It is submitted that an equitable pricing policy from the patient's point of view should satisfy the following criteria:

* the time taken to perform a particular service;

* the extent to which capital goods are utilised during the performance of the service;

* continuity of performance over time; and

* the specialization content of the performance.

However, even in this regard, the question may be raised as to what control measures may be implemented to prevent over-treatment, and consequent increased costs in order to satisfy the commercial orientation that some private practices have assumed. Logically, professional ethics and an adherence to the spirit of the Oaths i.e. the Hippocratic Oath and the Geneva Declaration (included as Appendix E) could serve as control measures. However, in view of the fact that ethics have a wide grey area, this seems unlikely.

The ability and the means used to purchase health care in the private sector determine the type and the combinations of diagnostic and therapeutic services that a patient will receive.

Payment for services may be made by one or more financial intermediaries such as medical aid schemes or health insurance plans. However, it is sometimes argued that some benefit plans are inflationary because of the conditions of contract, eg. patients have to be admitted to hospital for tests in order to be eligible for benefits rather than use an out-patients facility in the case of some benefit schemes. In order to reap the benefits from such schemes, the patients and doctors adhere to the terms as stipulated rather than opt for less costly alternatives, for which patients do not receive benefits.

5.4.2.1 Medical Aid Schemes

Medical aid schemes provide only for the economically active and their dependents. It was estimated that 7 125 312 persons enjoyed medical aid cover at the end of 1989 representing about 23.6% of the total population.[3] However,

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3. Statistics obtained from the annual report of the Registrar of Medical Schemes and is reflected in Appendix F.

with the rapid escalation in medical contributions per member, it is possible that not all of the economically active members will be able to afford these contributions in the near future. The considerable increase in medical aid subscription rates in recent times can be attributed to soaring costs of medicine, doctors fees, overuse of benefits, overservicing by practitioners, over reliance on secondary and tertiary means of health care rather than primary and preventative care, and inefficiencies in administration by medical aid schemes(Price & de Beer 1989:41).

In this regard Ross (1988:23) submits that third party reimbursement leads to greater (and perhaps unnecessary) use of health care.

> "When a third party pays for a service, consumption and the act of paying are separated in time and place. The consumer is usually not aware of the true cost of the service. There is little incentive for consumers or providers of services to be cost conscious and herein lies the the biggest issue of the health care problem".

In addition, the Registrar of Medical Schemes, provided the following reasons for the increase in his Annual Report on 22/3/91:

> "The sharp increases in the cost structures of medical schemes reflected over several years are, in my view, mainly attributable to over-utilisation of the system. Basically, the system lends itself to abuse since first Rand cover is coupled to fee-for-service guaranteed payment. Therefore, there is no incentive for either the consumer or the supplier of health care services to be prudent or thrifty".

In order to address some of these problems, it is suggested that the present legislative restrictions on medical schemes (in terms of the Medical Schemes Act 72 of 1967), be reviewed in order to render a more flexible and market-related health care system possible. Efficient claims management and successful measures to control fraudulent claims should be implemented to contain costs. It is also suggested that members of medical aid schemes become involved in finding a cure for the medical aid malaise, by

consulting practitioners only when really necessary. Perhaps, a system based on reduced contributions as a reward for low claims should be considered.

Practitioners too should exercise restraint in prescribing tests and expensive treatment unnecessarily. The effect of a judicious system of consultation on the part of members, would result in practitioners having more time to practice "good medicine" on genuine cases, and the use of expensive and harmful drugs would decrease.

Since serious reservations have existed about the solvency, adequacy and efficiency of several medical aid schemes, complementary health insurance policies have become popular. Those who are not members of medical aid schemes are also beginning to perceive the need for health insurance.

5.4.2.2 Health Insurance

Insurance companies are presently offering policies they claim will assist patients financially when they are in need of health care. Proponents of private health insurance might advance the following reasons for their stance:

* that the policy holder's tax burden would be decreased, since the premium paid is tax deductible;

* that patients' anxiety would diminish, since they would at least have the finance to pay for treatment needed without an erosion of their life savings;

* a competitive response from medical aid societies would be stimulated.

Proponents might further argue, that health care insurers are not bound by the Medical Schemes Act (72 of 1967 as amended) and that they can offer individually designed schemes, that would aim at cost containment while offering increased cover. Private health insurance is usually designed to supplement medical aid schemes by offering, inter alia, hospital and major surgery cover, regular income in case of accident or illness, financing of nursing and home care and other convalescence financing.

Despite the existence of financial intermediaries which assist in the payment of medical services, access to private health care is still limited because the majority of people in South Africa cannot afford even the contributions or premiums involved.

In response to the financial difficulty of gaining access to medical care, a new concept in health care was recently launched (Daily News. 28/11/91:12). The concept, initiated by EMSCorp, the Emergency Medical Services Corporation, was designed to offer an affordable and efficient service in emergency medical care. EMSCorp, in conjunction with its subsidiaries, EMSCare (which deals with patient services) and EMSPro (which incorporates the ambulance services), offers medical care programmes for the lay public, students, senior citizens, tourists, family units, as well as nursing, convalescent, rehabilitation and geriatric patient care centres.

Members pay a nominal fee per month for the various services that they may need.Some of the services provided by the Corporation are: twenty-four- hour medical advisory services, after-hours house calls, student training services and other

support programmes. A member of the EMSCorp Board submitted that they have undertaken these functions in an attempt to meet the challenges that the private medical sector faces.

5.4.3 Promotion

Promotion plays a modest role in the marketing of services, since services are intangible and there is a high degree of buyer dependence on the provider of the service. The heterogeneous nature of service performance among different individuals renders communication of some information to the public difficult and unnecessary.

Promotion is also frowned upon by some, and is indeed prohibited in South Africa by the SAMDC. Although the SAMDC acknowledges the desirability of informing the public about medical matters of general interest, it disapproves of advertising by medical practitioners. The question of whether practitioners should be allowed to advertise to the public has been debated on many occassions. Indeed this point is still debated in America where the ban on advertising by practitioners was lifted in 1977. Prior to 1977, advertising was prohibited by the codes of ethics of the American

Medical Association in an attempt to "protect consumers against their ignorance as well as potential professional incompetence and misrepresentation" (Labarbera & Reddy 1987: 43). However, several studies conducted in the USA (Wright and Allen 1981, Darling and Horckett 1978, Darling and Bussom 1977, Shapiro and Majewski 1983, and Meskin 1978 quoted in Labarbera and Reddy 1987: 44) after the ban was lifted revealed that the majority of medical professionals believe that advertising does not help consumers to make more intelligent physician choice. The majority of consumers on the other hand believe that advertising helps them to make intelligent choice of physicians.

The entrepreneurial nature of the US health care sector views health care as a very expensive commodity. Consequently consumers believe that they should be afforded an opportunity of making their own decisions as to who should attend to their health care needs. This issue needs to be probed within the South African private medical sector as well.

Because of the present prohibition on promotion some medical practitioners attempt to communicate with their markets through exposure or visibility in the form of participation in community activities, church and school boards. On a national level practitioners may obtain exposure through professionally oriented technical articles or papers presented at conferences or by publishing in accredited journals.

Other practitioners merely rely on their performance to speak for itself or on their patients' "word of mouth advertising".

It is thus submitted that the promotional element of the marketing mix can contribute to a shift in emphasis from curative medicine to preventative medicine through the use of, inter alia, advertising media, publicity seminars or even talks at gatherings on critical areas of health care. Total healthcare costs might as a result be reduced significantly and medical professionals could devote their time to other, more critical matters in health care.

Unfortunately, there is little evidence that practitioners view promotion as an integrated activity in the total service concept and therefore not much attention has been paid to this aspect as yet.

5.4.4. Distribution/Place

In the case of medical service and products, the relative importance of time and place utility is greater than in the case of goods because of the life-saving nature of these products and services. Location thus refers to the distribution of people and facilities prepared to perform services, while the channel may refer to a network designed to deliver the services, for example, doctor, specialist, hospital (Rathmell ed. 1974:182).

Medical services may be highly concentrated, as in the case of medical centres and hospitals or they may be dispersed as in the case of individual practices in suburban and rural areas. The inability to store such services and the need to have service facilities to meet intermittent emergency demands, is invariably reflected in the price. As private medical care assumes a greater role in the supply of health

care, the prompt and proper rendering of services at all times, including after hours services, becomes critical in satisfying patients/clients.

There appears to be a distinct shift from general to specialized practice with the patient paying higher prices in the health care market place. It is believed that while this trend toward specialization may improve the quality of medical practice in specialized areas, the patient's search for appropriate holisitic professional care is made more difficult since patients need to see many different specialists for different ailments. This may result in a postponement of treatment for some ailments, which is clearly not in the interests of the patient. In addition each specialist charges an initial consultation fee in addition to other fees, which discourages patients from using their services unless they see an absolute need for it.

It may be observed though that medical clinics or "one stop medical care facilities" have been established with a view to solving the problem of searching for specialists in different areas, since they are often situated in the same medical centre. However, the possibility is greater for

overservicing, since medical professionals are often the major shareholders in these medical centres and private hospitals, and have a vested interest in its profitable perpetuity (majority shareholding by medical professionals has been confirmed in interviews with senior administrators of 8 private hospitals and clinics in the study area).

In the USA, where surgeons are granted facilities at some private clinics, they are expected to use these facilities at their maximum. If they do not, the facilities are withdrawn by the administrators whose sole objective is maximization of profits. In this instance too, patients are at a disadvantage since specialists tend to overservice in order to remain eligible for the convenient facilities. Fortunately this practice has to date not been repeated in South Africa.

In other cases, also in the USA, some specialists are barred from using certain clinics or private hospitals because they operate their own private clinics or they are shareholders in other hospitals. This is clearly not in the interests of patients because it limits their choice of clinics and it poses a threat to the professional freedom of doctors.

It is evident that marketing mix options are for medical practitioners in South Africa, severely constrained by both legal and professional considerations. Partly as a result of this, they have felt a need to form associations which will protect their interests by means of co-ordinated action. The Medical Association of South Africa (MASA) is one such body and is recognized as the official mouthpiece of the medical profession.

5.5 THE MEDICAL ASSOCIATION OF SOUTH AFRICA (MASA)

MASA is described as an exclusive professional body of medical practitioners without statutory power which is concerned with the interests of doctors. It is registered as an association not for gain under Section 21 of the Companies Act (MASA 1986: 1). Membership is voluntary.

Among other noteworthy benefits enjoyed by MASA members, is the existence of a comprehensive professional liability insurance called the Medical Protection Fund. This Fund

provides assistance to doctors who have legal suits brought against them by patients or their dependents, for negligence or malpractice.

The Chairman of MASA, Dr B. Mandell acknowledged (on the John Berks Show on M Net at 20h00 2/8/90) that if a doctor knows that he has no reasonable defence, the matter will usually be settled out of court, with a payment being made from the Medical Protection Fund. This means that a doctor's negligence or misdemeanour does not affect him financially or otherwise, since he is not responsible for the payment and others are not made aware of the legal proceedings. This can hardly be considered a punitive measure for wrong suffered by the victims of malpractice.

There are several other associations to which doctors may belong, whose objectives are to protect the interests of practitioners and in some cases to facilitate the communicative processes between various organizations and the public. There is one group of concerned practitioners however, whose main objective is to promote the well-being of patients rather than their own. This voluntary vocal group of prac-

titioners, the National Medical and Dental Association (NAMDA) is primarily made up of academics and practitioners in the employ of state or provincial hospitals.

5.6 THE NATIONAL MEDICAL AND DENTAL ASSOCIATION (NAMDA)

NAMDA's main objective is to promote the idea of an equitable distribution of health care for all the people of South Africa, irrespective of their ability to pay for such care. Annual Conferences and Proceedings are arranged which serve as a forum for the presentation of their views. Their constant plea is that all medical personnel should contribute to an efficient and cost effective health care system, where the profit motive is subordinate to the patient's welfare.

However, the voice of NAMDA does not appear to carry much weight, and there is no recognised patient's association in South Africa which is vociferous enough to join forces with NAMDA to present an effective countervailing force against any perceived injustices that may be perpetrated against them. Medical Aid Societies are not acknowledged as patient's associations but as financial intermediaries which

attempt to address price increases only. Other associations such as the Heart Foundation and the Cancer Association provide only an informational and fund raising service and are not in a position to raise a collective voice against perceived injustices. It is indeed, doubtful whether consumerism in the medical sector in South Africa exists at all.

5.7 MEDICAL CONSUMERISM

An absence of consumerism in the medical marketplace stems probably from a lack of awareness of the rights of the consumer than from an absence of injustice or inequities. Moreover, the highly professional character of services and the apparently powerful doctors' associations that exist present a daunting task for non medical people who might wish to mobilize an effective association.

Nevertheless, against the background of consumerism in general, it is clear that consumers of medical services need to look after their own interests in a more organised way, with a view to increasing market power. A greater under-

standing of medical methods and procedures would be helpful in this regard but it is doubtful whether any widespread training programme would be feasible.

However, it is submitted that a campaign to increase awareness of consumers' rights in the medical marketplace would be an important step towards judicious assessments and legitimate expectations of performance quality.

The patients' rights in the medical marketplace,as suggested below, are believed to be logically consistent with the generally accepted consumer rights outlined in chapter 3.

the right to safety: to be protected against the marketing of dangerous drugs, medication and/or health aids; to be assured products will be safe, when used or consumed in their prescribed manner.

the right to be informed: to be protected against inadequate information in respect of possible ill-effects, or

side-effects of the medication prescribed, or of the dangers of using certain medical equipment in any other manner, except as prescribed. Relevant information should be easily understood and easily obtained.

the right to choose: consumers should have the right to choose the practitioners they consider most suitable for their needs. They should have the right to change practitioners if dissatisfied for any reason. They should also have a free choice of pharmacists.

the right to be heard: the practitioner has a duty to listen courteously to all and not only to some of the patient's medical complaints,

before making a diagnosis, since various relationships exist between different ailments. Further, the practitioner should take cognizance of medication previously taken that proved ineffective for the purpose diagnosed or that caused ill-effects or side-effects, should the patient inform him thus.

the right to consumer education: right to be made aware of the methods and procedures adopted by private practitioners and the State, to reduce the risk of contracting certain contagious ailments.

the right to redress: to be compensated for loss or damage suffered despite the proper use of prescribed

	medication.
	To be compensated for negligence or malpractice on the part of practitioners.

An appreciation of the concomitant responsiblities of patients should also be highlighted in order that issues are addressed in a responsible and fair manner. Corresponding responsibilities are suggested in Table 5.1.

TABLE 5.1: RIGHTS AND RESPONSIBILITIES OF THE CONSUMERS OF MEDICAL SERVICES AND PRODUCTS

	RIGHTS	RESPONSIBILITIES
1	to safety	to use medication and medical care equipment as prescribed. To acquaint oneself with the possible risks of abusing medication and equipment and to avoid such risks.
2	to be informed	to make a positive attempt to become aware of the characteristics of the medication being used and the possible ill-effects if abused.
3	to choose	legitimate dissatisfaction with practitioners or pharmacists should not be tolerated. Instead, the

		consumer should choose another without fear of non-treatment by the other.
4	to be heard	to make known to the practitioner, medication and treatments that were clearly non-beneficial when taken as prescribed. To make known to others, and to professional boards, details of misconduct on the part of the practitioner.
5	to consumer education	become conversant with rights, and duties as a citizen with regard to public health and to adhere to the methods and procedures prescribed by private practitioners or state authorities.
6	to redress	seek compensation for damage or ill-effects caused by prescribed use of medication or equipment. This may take the form of com-

plaints to the supplier or company concerned, statements to professional boards and/or news media and direct legal action.

Informed, responsible clients are more effectively able to evaluate the quality of performance received and to make decisions that would serve their best interests. A high quality of patient care and the judicious practice of medicine would translate into an increased recovery rate and an improvement in the quality of life after medical intervention. In order to ensure quality of performance, practitioners should be periodically subjected to peer review programmes or professional audits.

Indeed, it has been submitted by academics in the USA that a formal evaluation (professional audit) of medical graduates, whereby their competency and/or their professional practices are examined, would be the most rational way to assess the extent to which medical professionals achieve their purposes. Such an evaluation would be appropriate among South African graduates as well.

It is believed that these assessments would result in fewer misdemeanours and malpractice actions. However it has also been submitted that,

> "Outcome evaluation is extremely difficult to implement and to validate, because in its most comprehensive form, it requires long term prospective studies and the control of many variables extraneous to the institutional programmes that influence the quality of patient care and the practice of medicine". (Jama, Aug. 25, 1989, : 1008).

5.8 CONCLUSION

The debate as to whether South Africa should adopt some form of national health service or persist with current trends towards privatization of health care, is unlikely to be settled soon. There have been renewed calls for a national health service by high profile political figures who argue that free access to health care would improve the health of the nation and solve the escalating cost crisis. Moreover it is argued that a national health service would avoid the twin scourges of a privatized system : undertreatment or no

treatment of the indigent on the one hand, and overtreatment of those who are able to pay, on the other hand, merely because it serves as a basis for profit.

The adoption of a national health care delivery system in South Africa, would alter the whole medical care industry. There would be no vested interest in the illness of the people, no conflict of interests between pharmacists and dispensing doctors, no medical aid scheme malaise, no upsurge in medical insurance and no ineluctable fear of not being able to afford medical care. There would also be little incentive for doctors or pharmacists to work very hard.

On the other hand, if the current drive to privatize almost all state medical facilities continues, and self-seeking medical practitioners are allowed to exercise their quasi-monopoly powers to the full, current inequalities and iniquities might well fester into an incurable malaise. Only a strong countervailing patient's association and an enlightened public can effectively curb abuse of the system. Indeed, it is suggested that in the current political climate, it is only proactive responses to consumerism which

can save the private system and permit it to serve the interests of both practitioners and patients. There is therefore a pressing need for patients to exercise their rights and to "maximize their health care purchases."

Whatever system ultimately prevails, a fundamental aspect of the practice of medicine would continue to involve the subtle and delicate relationship between doctor and patient. This relationship should ideally go beyond the mere application of scientific and technical skills to the humane and empathetic rendition of services to trusting, yet anxious individuals. This relationship will be examined in Chapter 6, particularly as it appears to be the subject of much discontent among patients. This matter will also be probed in the empirical study in chapter 10.

CHAPTER 6

RELATIONSHIP BETWEEN DOCTOR AND PATIENT

6.1. INTRODUCTION

When a medical practitioner accepts a patient for diagnosis and treatment, both parties acquire legal rights and obligations. Patients usually turn to, and entrust their health and their lives to members of the medical profession, when they are unable to diagnose and treat themselves. They are usually in a very vulnerable position, willing to grasp at any form of relief. Their only concern is to regain their health, rather than a demonstration of a desire to exercise their rights. Indeed, they often suppress "complaints for fear of retaliation" (Annas 1991:138). It is therefore imperative that members of the profession respect their essential humanity and empathize with those they serve. In this regard Benatar (1987a:733) recommends that:

> "The humane application of scientific and technical skills in medicine requires a mutually respectful and trusting doctor-patient relationship. This demands of the doctor an awareness of the patient as a person in

the context of his beliefs and values, an empathic, ethically sensitive, compassionate concern for his predicament, and the ability to achieve effective two-way communication with the patient and his family."

Communication with the patient and/or his family is essential in developing a feeling of mutual responsibility. Communication should include the doctor's endeavours to inform the patient sufficiently as to the nature of the treatment/surgery and its possible consequences. In order to assume responsibility for his own well-being, a patient can only express a valid comment for his treatment/surgery on a basis of sufficient information. Gutheil (1984:49) believes that

"informed consent... is not an empty gesture toward liability reduction but an interaction... between physician and patient. Instead of squaring off defensively against each other, doctor and patient are brought together by the shared acknowledgement of clinical uncertainty and the fantasies used to deny it."

Obtaining a valid consent reflects the doctor's recognition of the patient's right to self-determination. Consent may be given expressly (i.e. orally or in writing) or impliedly by conduct. In South Africa, written consent is generally required when a patient enters a hospital and undergoes surgery (Giesen 1988:117).

Consent, either express or implied justifies medical treatment. An exception arises in the case of emergencies where the patient is unconscious and his next of kin is not available. Consent to medical treatment leads to a contract between doctor and patient.

6.2. THE CONTRACT BETWEEN DOCTOR AND PATIENT

The contractual relationship between doctor and patient is usually implied. However, it is difficult to define the existence, nature and extent of a contract for professional services.

The fact that a patient does not or cannot pay for the services of the physician does not affect the existence of the contract or lessen the doctor's liability for negligence thereunder. Indeed, the doctor is obligated to treat the patient with "due care" and failure to do so constitutes negligence for which the patient or the patient's dependants, may recover monetary damages under the law of delict.

> "The obvious first step in determining due care is consideration of the amount of skill possessed and used in treating the patient. A physician may be liable either for failure to know what he is doing, if a reasonably prudent physician would have known, or he may be liable if he knows what to do, but for some reason does not do it carefully or omits doing it at all. A physician may, for example, be liable in negligence if he is remiss in his obligation to realize that he is not capable of treating the patient and should therefore send him to a specialist. Failure to visit a hospitalized patient sufficiently frequently to keep aware of his problems, on the other hand, would constitute lack of diligence " (Holder 1975:42).

The duty of care may in certain circumstnaces even extend to third paries. Nelson-Jones and Burton (1990:24) contend that the duty of care

> "adheres to any person who holds himself out as a medical practitioner and is owed not only to patients but also to certain classes of third parties recognised by the law as being so closely and directly affected by the treatment or advice that the doctor ought to have them in mind. In medical malpractice actions, such third parties may be the offspring of women, who while they were pregnant received treatment which resulted in the so-called wrongful birth of the child, such as in cases of failed sterilization. In some cases the child may also be born with disabilities."

The duty of care also extends to employers of health personnel.

The general rule in law that the employer (principal) is liable for the negligence of his employee (agent), is also applicable in the case of a hospital and its employees. This

is designated as being vicarious liability, according to the doctrine of "respondent superior" (let the master answer)(Mostert 1986:536).

For employees to come under the umbrella of the employer's coverage, two elements must be established:-

* that there is indeed an employer-employee relationship; and
* that the employee acted on behalf of the employer and within the general context of his or her employment (Mostert 1986:536).

An exception to this form of vicarious liability arises when an employee acts with intentional malice outside the scope of employment. In such a case the employee and not the employer, will be liable for negligence.

6.3. NEGLIGENCE

Doctors in private practice, and hospitals which employ doctors, thus have an implied contractual "duty of care." Failure to exercise such care would constitute negligence and render them liable to legal actions by patients

(Joubert 1983:151). Care and corresponding negligence is clearly an issue of central importance in the doctor-patient relationship. Nathan (1957:2) stipulates further, that

> "In strict legal analysis, negligence means heedless or careless conduct, whether in omission or commission: it properly connotes the complex of duty, breach and damage thereby suffered by the person to whom the duty was owing " (Nathan 1957:2).

The complexities that arise in some doctor-patient relationships have prompted legal intervention, which does not always produce desirable consequences. According to Mason & McCall Smith (1987:15)

> "the defining of a relationship, such as that of doctor and patient, in legalistic terms leads to a subtle but important change in the nature of the relationship. What the law expects of the doctor may mirror closely what codes of medical ethics expect, but the basis of compliance in each case is essentially different. Trust and morality are more likely to flourish in a relationship which is governed by morality rather than by legal rules and, no matter how appropriate the law may be for

> the regulation of many of the other ordinary transactions of life, the injection of formality with excessive caution into the relationship between doctor and patient is ultimately not in the patient's interest if it means that each sees the other as a potential adversary."

Where an allegation of negligence is made against a physician, only another doctor or panel of doctors can assess technically whether the plaintiff has a prima facie case. Medical negligence is accordingly determined by the standards of reasonable care set by doctors themselves.

> "But a doctor is the very last person who will speak out on these matters and his refusal to do so undermines the legal process, which rests upon expert testimony, thereby tearing at and mutilating the warp and woof of the social fabric" (Birrer 1976:106).

Powers & Harris (1990:90) have also observed that

"The major problem for victims of medical accidents is that the people who should help and are best placed to help them, the doctors, are least willing to help, and in many cases obstruct them."

There is no medical body available to address the problems for doctors who find themselves in the position where they have or may have been involved in acts that resulted in unnecessary injury to patients (medical accidents), other than in respect of the financial issues.

The time is long since passed when the medical profession should set up an organisation to help and advise doctors on the issue of medical accidents from an ethical, medical and personal point of view, leaving the defence organisation to deal with what they are best at doing. Such a step will not only help doctors but it will fundamentally change the situation for victims as well.(Powers & Harris 1990:90)

With regard to the camaraderie among doctors, another question may be raised. Should a doctor's allegiance to his professional brother supercede his duty towards humanity itself? The logical answer to the question is "No!". Profes-

sional ethics which are based on the Hypocratic Oath place the interests of humanity first. However, a legal system which allows frivolous actions to be brought against doctors and which awards sums to plaintiffs which financially cripple doctors, might well "boomerang" on humanity. In this regard Birrer (1976:106) notes that it is essential in malpractice litigation to strike a reasonable balance between the protection of the legitimate interests of a patient injured through medical negligence and protection of the medical profession in its service to mankind. If this balance is not established, she adds, the everpresent fear of legal action might result in doctors avoiding procedures which carry great risk, but which might nevertheless be valuable to patients.

Clearly, leaving a swab inside a patient is gross negligence and therefore inexcusable. Such a patient can invoke the res ipsa loquitor principle (the thing speaks for itself). However, for a successful action, the patient must prove that the negligence caused an injurious result.

In the prescription of medicine, a doctor might also be negligent. For example, should a doctor deviate from the recommendations printed in the package insert provided by pharmaceutical companies the doctor would, prima faci be guilty of negligence and be liable for damages if there is competent medical testimony that the patients' injury or death resulted from such negligence.

The performance of operations without the consent of the patient might in some cases also constitute negligence. On this point, Laskin J.C. (in the English case of Hopp v Lepp 1980 112 DLR 67,70) noted that it is not only a question whether the doctor has carried out his professional activities by applicable professional standards. He added:

> "What is under consideration is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or treatment... There is nothing especially 'medical' about the requirement that a doctor must obtain a patient's consent, and that he must sometimes disclose information to the patient before the patient decides whether to consent. These requirements are imposed, not in the interests of the patient's

health, but in the interests of individual liberty. The basis is the right of a patient to decide what, if anything, should be done with this body."

In this regard, Nelson-Jones & Burton (1990:66) point out that

"Failures of communication stem from the imbalance of knowledge, arguably accompanied by an imbalance of power, which is found at the base of the doctor/patient relationship".

The courts have, to some extent, sought to redress this balance in two ways: firstly by holding that any interference with a patient's body without his consent can amount to battery, secondly by deeming a practitioner to be negligent if he falls below the standard of due care in informing or advising his patient. (Nelson-Jones & Burton 1990:67).

While there has been a multitude of successful court actions involving medical negligence in the U.S.A., the number of cases in South Africa is relatively small. Accordingly, the question has often arisen, as to whether the nature of the

legal relationship which now exists in South Africa between doctor and patient is equitable and satisfactory. In this regard, Strauss (1976:15) claims that not one out of a hundred cases of alleged medical malpractice in which lawyers are consulted end up in the courts. He suggests several reasons for this, namely:

* There are many difficulties for the plaintiff to discharge the onus of proof which rests on him, since lawyers experience considerable difficulty in obtaining professional medical witnesses to testify for the plaintiff.

* There is a spirit of cameraderie "or a conspiracy of silence" among physicians which precludes their participation in the litigation process. Moreover, there are practical difficulties in getting them to testify, such as disruption of their lucrative practices,and consequential financial loss.

* There is undue financial risk for the plaintiff: if the case is lost the heavy legal costs must be borne personally. If the doctor loses the case he is unlikely to suffer severe financial loss since most members are insured against possible malpractice suits. It may also be speculated that, the South African courts seem reluctant to find in favour of plaintiffs for fear of duplicating the U.S.A. experience, where vast numbers of lawsuits, often trivial, are now brought against doctors for substantial monetary damages. Although such a stance if true, is understandable, it does not necessarily result in an equitable system of justice.

The Medical Association of South Africa has stated (MASA 1986:12) that it has resolved to appoint a panel of medical experts to be at the disposal of the South African Medical and Dental Council for its investigations into malpractice and negligence. Panel members will also testify in criminal courts when expert testimony is required. It should, however, be noted that this service is not available to litigants in civil cases.

A complaint to the SAMDC does not receive any monetary award even if the relative doctor is found guilty of misconduct. The doctor will be penalized in a manner in which the Disciplinary Committee considers appropriate. For damages to be awarded, the complainant would need to win a civil case against the doctor in a court of law. It seems that the findings of complaints to the SAMDC are not automatically published in the press.

It is suggested that there should be mandatory feedback in all cases of alleged malpractice and/or negligence, which are investigated by the disciplinary committee of the SAMDC. When a doctor has been found guilty for an offence by the SAMDC, its findings should similarly be made public in the news media, as a deterrent to other doctors and to create a greater awareness among patients in respect of the response that they may expect to complaints.

An analysis of the medical practitioners' conduct in a given situation in relation to accepted standards of practice, would provide guidelines for other physicians who are sometimes placed in similar situations. The analysis would also

constitute a basis for delineating patients' rights in health care. Information rights enable the consumer to make rational informed decisions, while considering his own individual or typical interests. "The concept of information rights presupposes that consumer self-determination is attainable" (Hart 1989:343).

In response to patients' desire and need for more information, the National Council on Patient Information and Education (in the USA) called for the re-introduction of good, clear communication about medicine. The (AMA) American Medical Association too, is actively promoting improved patient communication, since communication is an essential component for increasing patient trust (Borten & Friedman 1990:7).

Moreover, an informed patient would positively acknowledge, respond to and appreciate a demonstration of professional ethics and empathy.

6.4. PROFESSIONAL ETHICS AND EMPATHY

A humane and ethical medical approach by all practitioners would obviate any call for a patient's ombudsman or a patients' bill of rights. However this seems to be a Ut opian ideal.

Hospitals and clinics too, would need to adopt a positive and ethical stance towards patients, inter alia, by not including unethical disclaimers in admission forms which strip the anxious and vulnerable patient of all rights. At that time patients are seldom in a position to read this fine print; let alone question it or refuse to sign it. An example of such a disclaimer at a private clinic reads thus:

> "It shall be a further condition of admission to and treatment at this Hospital that the Hospital shall not be liable for any injury loss or damage of whatsoever nature to me or anyone on whose behalf I hereby act arising out of any treatment or attention received or defects in the premises or ways or work or instruments

of the Hospital and whether due to the negligence of the Hospital, its servants or professional staff or not " (SAMJ. 1986. : 27).

It might be argued that a medical code of ethics should inter alia require all involved in the medical "industry" to respect the patient as a person with feelings and fears. The suffering, frightened patient needs empathy, reassurance and support, but rarely seems to receive it from the modern physician.

The distance between patient and doctor is clearly increasing as the technology of medicine advances. Some family physicians do continue to be familiar, reassuring and even therapeutic figures in the complex technological conveyor belt system of modern health care. However, this demands much time, and many physicians cannot serve in this capacity due to their demanding schedules.

On the other end of the scale there are many practitioners who have been accused of complete indifference and gross insensitivity. Indeed, a survey conducted in the U.S.A. had

revealed that many patients would not have sued their doctors but for the doctors' indifference when things went wrong and for their refusal to admit faults (Birrer 1976:87).

More recently a survey of patients (in Chicago, USA) who initiated malpractice suits against their doctors, revealed that anger and frustration generated by unmet expectations of the patient, were significant factors that triggered an adversarial relationship between patient and doctor (Holzer in Borten and Friedman 1990:7).

At the Seventh General Practitioners' Congress in South Africa (Daily News 12/6/90:5) a medical doctor expressed his "dismay and disillusionment" at how his own dying father and his family were attended to by the doctors concerned. He added: "we have managed to develop superb technicians who lack in counselling skills in general, and empathy in particular." Furthermore, "we are failing in a crucial area of care and unless we start addressing the problem soon, we will be left behind to perform only technical tasks." Similar sentiments have been expressed by Mappes and Zembaty

(1991:46) where they feel that current attitudes toward physicians are different, due to many factors, including the following.

Firstly, they feel that the physician-patient relationship has become increasingly impersonal as the growth of medical knowledge and technology has made modern medicine more complex. Growing complexity has led to an increase in specialization and the growth of large depersonalized medical institutions.

Secondly the rise of 'iatrogenic illnesses' (illnesses resulting from medical interventions), has sometimes raised doubts about the skills of physicians. Publicity about medical mistakes, and questionable medical practices has further eroded some of the lay trust in the judgements of physicians and in their selfless dedication to their patients' well-beings.

Thirdly, a growing awareness of the economic and educational difference between physicians and many of their patients has resulted in doubts about the capacity of physicians to perceive the best interests of their patients and to act accordingly."

Clearly, there exists a need for an equitable doctor-patient relationship which reflects the moral responsibilities of the participants. In response to this, various models of doctor-patient relationships have been suggested.

6.5. MODELS OF DOCTOR-PATIENT RELATIONSHIPS

Beauchamp and McCullough (1991:59) explore two models of moral responsiblity among doctors. The first model, the beneficence model expresses the moral signficance of seeking the greater balance of good over harm for another. This is characterised by paternalism which

> " is the interference with; limitation of, or usurpation of individual autonomy justified by reasons referring exclusively to the welfare or needs of the person whose autonomy is being interfered with, limited or

usurped. In acting paternalistically, physicians in effect act as if they, and not their patients, are best able to identify what is in their patients' best interests as well as the best means to advance these interests."

It is believed that the Hippocratic Oath reflects the traditional paternalism of the medical profession since the oath requires doctors to act so as to "benefit" the sick and "keep them from harm", but no mention is made of patients' rights.

Annas (1991:138) has also observed that

"Paternalism is the norm with the majority of physicians believing that the health and continued life of their patients is much more important than their patients' rights to self-determination. This belief system not only leads to conflicts with the individual patients about their own care, but also to a general view that sees patients' rights as being a luxury item in medicine rather than a necessity."

In the light of this change towards patients' self-determination, Beuchamp and McCullough (1991:63) posit the second model, the autonomy model which interprets the best interests of the patient exclusively from the perspective of the patient. In this instance the doctors' respect for their patients' values and beliefs is fundamental in determining the doctors' values and responsibilities.

They contend that although the models appear to be in opposition, a closer examination of them, reveals that each model captures only a valid but partial perspective on the responsibilities of doctors. Consequently, they believe that medicine is enhanced and dignified by both, although they may at times appear to conflict with each other.

Veatch (1991:55) on the other hand, presents four models for the moral relationship between doctor and patient:

* The Engineering Model where the doctor is an applied scientist who presents the facts to the lay person, and leaves decision-making to the latter. This requires the doctor to divorce himself from all considerations of value;

* The Priestly Model where the doctor plays a paternalistic role in relation to the patient. This appears to be consistent with the beneficence model of Beauchamp and McCullough;

* The Collegial Model where the doctor and patient are viewed as equal colleagues sharing common interests and striving for the common goal of eliminating illness and preserving the health of the patient. Trust and confidence play the most crucial role in this model.

* The Contractual Model where parties are expected to interact in a manner where there are obligations and benefits for both parties. Although the premise of trust and confidence are recognised, a complete mutuality of interests is lacking. However, the basic norms of freedom, dignity, truth, promise and justice are essential to this relationship.

In the contractual model, the moral abdication of the doctor in the engineering model, the moral abdication of the patient in the priestly model, and the false sense of equality in the collegial model are avoided.

Veatch (1991:58) contends that

> "In the contractual model there is a real sharing of decision-making in a way that there is realistic assurance that both patient and physician will retain their moral integrity. In this contractual context patient control of decision-making on the individual level is assured without the necessity of insisting that the patient participate in every trivial decision... The locus of decision-making is thus in the lay community, but the day-to-day medical decisions can, with trust and confidence, rest with the medical community. If trust and confidence are broken, the contract is broken."

On the other hand, Pellegrino (1987:33), Director of the Kennedy Institute of Ethics in Washington, acknowledges the problem facing medical practice as

"comprising a progressive erosion of public confidence in the traditional sources of medical morality, a gradual decline of professional commitment to all the injunctions of the Hippocratic Oath and the kind of life it enjoins, and a wide divergence on values and opinions on many moral dilemmas in medicine."

In an attempt to address these problems, Pellegrino proposed that a philosophical reconstruction of professional ethics be sought, which is derived from the nature of medicine and medical acts and their interrelationships in the art of healing. The obligations for the medical practitioner within such an ethic are technical competence, respect for the individualised nature of the doctor - patient relationship and commitment to the autonomy, dignity and moral agency of the patient. The corresponding obligations which the patient should meet are trust in the competence of, and respect for the moral agency of the physician.

Benator (1987:33) advocates that

"the art with which medicine should be practised refers to the wisdom, prudence, compassion, patience, sensitivity to ethnical issues with which doctors apply scientific knowledge to the care of their patients".

Consequently, it can be seen that the adoption of one of the models described above would be too simplistic, given the complexities that are inherent in the doctor-patient relationship. A model that would be conducive to an equitable doctor-patient relationship must reflect a prudent application of scientific knowledge together with an acknowledgement of the moral/ethical duties and responsibilities of both doctors and patients.

6.5. CONCLUSION

Modern medicine appears to be sadly lacking in a masterful blend between humanism and scientific expertise, much to the detriment of the doctor-patient relationship.

Since it has become clear that the inculcation of humane values cannot be left solely to the devices of individual doctors, it is imperative that such a programme be included

in the formal educational system for medical students. A reconstruction of professional ethics may materialize upon an analysis of models of doctor-patient relationships. However, it appears to be difficult to reach a consensus in this regard.

It is extremely unlikely that the Utopian ideal of perfect doctor-patient relationships will ever materialize. Accordingly, the patient needs some form of protection. In the next chapter, therefore, the extent to which consumers are protected in the medical field, will be examined within the framework of general aspects of consumer protection.

CHAPTER 7

CONSUMER PROTECTION IN THE MEDICAL SECTOR

7.1. INTRODUCTION

The law relating to consumer protection is not a clearly defined code. In fact there is no consumer law as a single entity. It is usually made up of extensions and amendments to contract law, designed to effect specific control over potential injustices and exploitative actions against the consumer. Corbett (undated paper) describes consumer law, as

> "representing an extraction of those principles and rules of the law of contract which pertain to the legal position of the person to whom such goods, services or credit had been supplied and more particularly the principles and rules which inure for his legal protection in the transaction into which he has entered."

Consumers in South Africa are protected by Common Law as well as by Statute. Some of the more important aspects thereof will be discussed in this chapter.

7.2. LEGAL PROTECTION OF THE CONSUMER

Although South Africa appears to lag behind major western nations in respect of specific consumer protection legislation, there are nevertheless some statutes that afford protection to consumers, such as the Foodstuffs, Cosmetics and Disinfectants Act 54 of 1972; the Harmful Business Practices Act 71 of 1988 (which superceded the Trade Practices Act of 1976); Price Control Act 25 of 1964; Credit Agreements Act of 1980; Drugs Control Act 101 of 1965; the Hazardous Substances Act 15 of 1973; the Weights and Measures Act 13 of 1958; the Public Health Act 36 of 1919; the Dairy Industry Act 30 of 1961; the Marketing Act 59 of 1968; and the Standards Act 33 of 1962 which provided for the establishment of the Council of the South African Bureau of Standards.

Common Law on the other hand deals with the rights of consumers and the responsibilities of sellers in a very wide context. Consumers are for example, protected against latent defects through Common Law, by virtue of an implied warranty.

7.3. LATENT DEFECTS

A warranty against latent defects and unsatisfactory goods and services is implied in common law even if the seller does not mention that the goods or services are guaranteed. The buyer can expressly waives his rights, in which case, the buyer cannot bring any action if a fault arises.

However, there are no warranties against obvious faults which are discernible to a reasonable person or if products are sold "as is", "voetstoets" or "with all faults".

The consumer who has discovered a latent defect or a fault, may cancel the sale upon returning the product and is entitled to a refund of the purchase price of the product.

Where a seller is a manufacturer, or advertises "skill and expert knowledge", the buyer may claim damages as well as a refund of the price paid without proving fault by the

manufacturers, unless he signs a guarantee card which includes "exemption clauses" or other "unfair" contract terms (Volpe 1986:116).

7.4. EXEMPTION CLAUSES

Many sellers attempt to protect themselves against actions by buyers in respect of latent defects or unsatisfactory goods and services by including "exemption clauses" in contracts. By signing the contract the buyer effectively waives common law rights. For example, exemption clauses are a common feature of contracts between private clinics or hospitals and their patients which are entered into at the time of admission. The purpose of these exemption clauses in contracts, signed by patients, is to indemnify the hospital and staff. Many of the contract terms are considered as being unfair, since the patient is placed in an extremely compromising situation. Being in need of urgent treatment or surgery, there is little inclination or time to consider or object to the implications of a contract which has been carefully drawn by hospital authorities. The patient or next of kin very often signs such documents without even

reading them. Should a patient wish to object to certain clauses, he might still not do so for fear of being denied admission. A lack of knowledge about the law of contract can thus prejudice a patient.

The need for consumer protection in the medical field furthermore arises because most patients are uninformed about health procedures and therefore are unable to judge the type of service they require, or the quality of service rendered.

7.5. CONSUMER INFORMATION

Undoubtedly, an important element of consumer protection is consumer information. However, as far as professional medical services and products are concerned, there are very few consumers who are well informed, simply because of the highly scientific, complex and sophisticated practices and procedures that are employed in the diagnosis and treatment of ailments. Another important factor is that demand is very often determined by the suppliers rather than the users, since practitioners prescribe diagnostic procedures and treatment and patients merely adhere to their prescriptions.

Consequently it may be seen that a lack of information and competence to form opinions on medicinal products are typical of the patient (Hart 1989:345).

Patients are so vulnerable to overservicing, overtreatment, exploitation and infringement of personal rights that some form of legal protection seems to be imperative. At the very least exemption clauses should be forbidden.

Equitable standard contractual terms should perhaps be drawn and agreed upon by representatives of both hospital authorities on the one hand and representatives of patients' associations on the other. However, before such a step can be taken, a recognised patients' association would need to be established in South Africa.

Lest it be thought that patients are at the complete mercy of the medical fraternity, it is important to note that some legal protection does already exist. One aspect of such protection relates to confidentiality.

During the course of consultations and treatment, practitioners become aware of intimate and private details about patients, which if divulged to outside parties, might seriously jeopardise their lives. Whatever information a doctor has about a patient should thus remain confidential (Joubert 1983:153).

7.6. PROTECTION OF PRIVACY/MEDICAL CONFIDENTIALITY

The patient has a right to confidentiality which can only be waived by the patient or by a court order. Taitz (1990:29) defines medical confidentiality as

> "the duty cast upon a medical practitioner, by reason of his calling and his special relationship with his patient, to keep secret and confidential all, and any information, whether relating to a patient's ailment or otherwise, which information was obtained directly or indirectly by the practitioner as a result of the doctor-patient relationship."

A breach of this duty of medical confidentiality, may result in an action against the doctor under the heading of

(i) a breach of the doctor-patient contract;

(ii) defamation; or

(iii) invasion of patient's privacy.

In addition to any civil action which may be taken, the doctor may face disciplinary action by the South African Medical and Dental Council (SAMDC), since a breach of confidentiality is regarded as improper or disgraceful conduct. An infringement, therefore, of Rule 16 of the SA Medical and Dental Council Rules, consists in

> "divulging verbally or in writing any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient or in the case of a minor with the consent of his parent or guardian or in the case of a deceased person,with the consent of his next-of-kin or the executor of his estate." (McQuoid-Mason 1988:82).

In addition, the International Code of Medical Ethics which was adopted by the World Medical Association in 1949, the Hippocratic Oath and the Declaration of Geneva of 1948 (See Appendix E) to which South African practitioners subscribe

also demand that the patients' secrets be respected. However, in a legal action, professional secrecy may be breached if the presiding judicial officer orders the doctor to do so. (Joubert 1983:155)

The rule of confidentiality extends to prisoners/detainees as well (McQuoid-Mason 1988:83).

Common law also provides for the protection of the privacy of the individual (Strauss 1980:60). It is entrenched in the law of personality. Disclosure by a doctor without the consent of the patient or his parent/guardian in the case of a minor or his next of kin or the executor in the case of a deceased person, except on a legal ground of justification, may result in an actionable wrong. (Estherhuizen v Administrator of Tvl 1957 3 SA 710 T).

Indeed, the courts have gone further in that they regard invasion of privacy as an aspect of impairment of dignitas under the actio injuriarum (McQuoid-Mason 1978:98).

McQuoid-Mason also submits that academics in South Africa recognize three categories of wrong:-

(a) intrusion into a person's private life;

(b) public disclosures concerning a person's private life; and

(c) disruption of a person's quiet or peaceful life.

Furthermore, no indication is given as to what the limits of privacy should be. So it is logical to assume that the courts have much latitude in determining whether or not individual rights to privacy have been infringed.

However, certain instances of disclosure are not actionable: viz, the disclosure to staff and accountants employed by a doctor, who are traditionally also sworn to secrecy; and the medical scheme to which the patient belongs.

The aspect of confidentiality must also be observed towards each marriage partner individually, unless each partner waives this right. The confidential relationship exists even if one spouse pays the medical fees of the other (Shapiro 1983:5).

A doctor may also not be compelled to disclose information to a party involved in a lawsuit, or his attorney. However, he may be subpoenaed to court as a witness, in which case he may testify only if so ordered by the court. Indeed, Shapiro (1983:5) recommends that professional secrecy should be contravened only under protest, after direction from the presiding judicial officer.

In some instances, however, modern codes of medical ethics have acknowledged that doctor-patient confidentiality is not absolute, especially when it becomes necessary to protect the welfare of the community. Accordingly, some diseases such as smallpox, tuberculosis, congo fever, cholera and typhoid fever have been categorised as notifiable diseases. Patients and/or doctors are compelled by law to inform the relevant authorities if the patient is suffering from such a disease so that others may be protected.

However, although AIDS (Acquired Immunodeficiency Syndrome) is not a notifiable disease, (Taitz 1990:30; Van Wyk 1991:149) it has nevertheless proven to be a menace to unsuspecting members of society, especially medical personnel,

and the families of AIDS victims. Therefore, it has been submitted that the law may have to make inroads into the rights of the AIDS victims.

7.7. THE RIGHTS OF AIDS VICTIMS

The SAMDC has presented guidelines concerning ethical considerations regarding AIDS patients (Bulletin of the SAMDC No.6. Sept. 1989). In terms of these guidelines the doctor has a duty to discuss fully with the Aids patients, the nature of the illness, treatment and its potential hazards, the need to inform fellow health care workers and the patient's sexual partners. In fact, it would seem that the SAMDC has conferred an obligation on practitioners to disclose this information, in a bona fide manner to health officials, since the relevant resolution states that

> "an act or omission on the part of the practitioner which could lead to the unnecessary exposure to the HIV infection; would lead to a disciplinary action" (Lee 1990:176).

In reaching the decision to "inform", the doctor's ethical responsibility toward the individual patient needs to be weighed against the interests and health of the community at

large. However, damages may be awarded for breach of confidentiality if information is divulged to other third parties (McGeary v Dr. Kruger Daily News 13/9/91:3).

The SAMDC's guidelines evidently point towards protection of the community, since AIDS is as yet an incurable communicable menace which is dreaded by many. Indeed even "the doctor suffering from AIDS has a moral duty but probably no legal duty to inform his patients of this" (Van Wyk 1991 : 148). It is also submitted that an AIDS patient who does not warn his/her sexual partner, but who infects the partner with the HIV virus, could be guilty of "murder" should the partner die as a result of contracting the HIV virus.

7.8. MEDICAL SECRECY AND MEDICAL CERTIFICATES

When a patient consults a doctor and asks him for a medical certificate, the doctor is entitled to disclose the diagnosis in the absence of a prohibition by the patient. A statement of the diagnosis usually authenticates the certificate. However, if the doctor considers that disclosure of the diagnosis may not be in the interests of the patient, he may legally omit any reference to it. Employers may not

compel doctors to provide detailed information of an employee, unless the patient consents to the provision of such information.

The doctor would not be responsible in any way, should the employer dismiss the employee who prohibited the doctor from providing detailed information regarding his diagnosis. On the other hand, a patient who consults a doctor who is employed by the patient's own employer, and "who has a duty to the employer to examine employees and to record and report to the employer medical facts pertaining to employees", may not prohibit the doctor from disclosing information (Strauss 1980:67).

Certain statutes in the field of industrial legislation, (viz. the Factories, Machinery, Building Work Act 22 of 1941, the Apprenticeship Act 37 of 1944, and the Workmen's Compensation Act 30 of 1941) provide for employers to specifically request information from doctors pertaining to their employees' or prospective employees' health. Under these circumstances all information must be surrendered, and the doctor may not be sued for a breach of confidentiality.

A fraudulent medical certificate on the other hand "exposes the certifying doctor to a criminal charge of fraud, as well as to disciplinary action by the SAMDC" (McQuoid-Mason 1988:79).

7.9. PRACTITIONER'S MEDICAL RECORDS

Practitioners are not legally bound to keep records of their patients. However, proper records have been found to be indispensible to the practitioner in gauging the progress of a patient's condition. Strauss (1980:70) adds that the records may be of utmost importance in the event of a malpractice suit against a doctor.

However, the patient has no rights to these records, unless the patient has formally instituted action in court by means of a summons.

Although the law recognizes that medical practitioners have a legal duty to observe secrecy in their professional capacity, this does not release the practitioner from the

obligation to provide evidence in court if called upon to do so. Medical practitioners in South Africa, unlike lawyers, do not enjoy professional privilege. They are obliged to breach professional secrecy when required by a competent court or a statute to do so. Indeed, they may be liable for contempt of court if they refuse to provide the information required by the court (Shapiro 1983:4).

However, a practitioner who is sued by a patient, or who is prosecuted on a criminal charge as a result of a complaint by a patient , does not commit a breach of secrecy if he divulges confidential information as a necessary part of his own defence.

Furthermore, as regards criminal matters, the criminal code provides that doctors may be summoned to appear before a magistrate to furnish investigating authorities with information pertaining to a suspected crime.A practitioner who refuses to breach his professional secrecy when ordered to do so by a magistrate, may be sentenced to imprisonment (Shapiro 1983:10).

It has been suggested by Shapiro (1983:12) that a practitioner who has information concerning a rape or gunshot accused has a duty to disclose his records when the information has been obtained as a result of an examination of the accused person upon the request of a competent authority. Ordinarily, there is no legal obligation on a practitioner or any other person to volunteer information about a crime (Taitz 1990:31).

With regard to deceased persons, Taitz (1990:30) adds that confidential information ascertained prior to the demise may only be disclosed with the consent of the next-of-kin or the executor of the estate. However, the practitioner is protected if there is a conflict between the next-of-kin and the executor.

The findings of a post-mortem examination, undertaken at the request of a magistrate, should be communicated only to the magistrate or to his duly authorized deputy.

It must also be pointed out that it is not only the practitioner who has a legal duty to observe secrecy. The pharmacist too, who is a link in the medical sequence of events, is obliged to observe patients' rights to privacy.

7.10. THE PHARMACIST AND CONFIDENTIALITY

The pharmacist is subject to ethical and legal obligations which are gazetted in terms of Section 41 of the Pharmacy Act. The first ethical rule prohibits the disclosure to any person of the nature of the disease or ailment being treated, except by order of a court of law (Schnell 1983:19). This prohibition extends to disclosure of the medication prescribed since such disclosure might lead to the identification of the disease suffered by the patient.

Section 34 of the Medicine and Related Substances Control Act 101 of 1974 also forbids the disclosure of any information acquired while carrying out any duty, except in certain specified circumstances. It should be bore in mind, however, that use of computers by pharmacists renders them vulnerable

to unintentional infringement of confidentiality, since computer operators are not bound by any statutes or codes of ethics.

Undoubtedly, use of the computer for the collection, processing, retrieval and transfer of data, represents one of the greatest threats to the privacy of individuals. Possibilities exist for information profiles to be incorrectly interpreted; to be accessed by unauthorized people; or to be used for purposes other than that for which they were collated.

Attempts to control data banks are commendable but they cannot guarantee inaccessibility, given the nature of the electronic systems. Control measures may be implemented to some extent by building in technical safeguards and by adopting secure administrative procedures. Fortunately for them, doctors and pharmacists will be protected from lawsuits once they have contracted with computer professionals.

Similarly, notwithstanding the fact that medical aid scheme personnel are not sworn to secrecy, they process prescription copies and detailed medical statements from practitioners. Logically, the pharmacist and practitioner cannot be held responsible for infringements within medical aid societies. By creating a legal obligation on medical aid personnel to observe secrecy, a form of control measure might be implemented.

Another area in which patients are afforded protection is in the case of malpractice.

7.11. MALPRACTICE

Malpractice consists of either wilfully wrong or negligent conduct on the part of a person professing particular knowledge or skill. It is often referred to as professional negligence (Nelson-Jones & Burton 1990:97). Negligence damages the doctor-patient relationship as does the failure of doctors to explain honestly to patients that they have been the victims of a medical accident or of negligent or careless therapy (McClean 1988:149).

The injured party in a malpractice case has a right of action for any pecuniary loss sustained and\or for unnecessary pain or suffering caused. In this regard Mostert (1986:536) submits that "it is a fundamental tenet of law that the tortfeasor is liable to damages awarded to the plaintiff who is injured by the mishap".

Consequently, a medical doctor, as an expert in the art and science of medicine, is expected to treat patients with a higher degree of care than that which is expected of a nurse or other paramedic, having less training and lower qualifications. Borten & Friedman (1990:51) submit

> "Indeed, it is even possible that the chief of medicine in a hospital, could be found negligent in his administrative capacity for failure to take action that guaranteed a high standard and quality of care being rendered within his facility",

if he knows or should have known that a particular doctor is negligent or incompetent.

Various aspects of malpractice will now be discussed with their attendant implications.

7.12. MISDIAGNOSIS

A doctor is expected to use the same degree of care in making a diagnosis, as in the case of treatment and surgery. A doctor would be liable for a mistake in diagnosis if he failed to conduct tests which a competent practitioner would have considered appropriate, or if he fails to notice a condition which a competent practitioner would have noticed (Lewis 1988:271; Strauss 1980:258).

In addition, failure to have certain patients submitted for X-rays, when conditions warrant it, may also be construed as negligence. A doctor is also liable if he knows he is not properly equipped to make a proper diagnosis and fails to refer the patient to a qualified colleague (Medical Defence Union Annual Report 1978 : 5).

It must also be pointed out that failure to inform a patient of a diagnosis that requires a patient to take precautionary measures to protect his health, also constitutes negligence on the part of the practitioner (Strauss 1980 :258).

7.12.1. DIAGNOSIS AND TREATMENT OF NON-EXISTENT DISEASES

A doctor is liable, where a problem exists and he diagnosis the problem as being of another type and thus treats the patient inappropriately. For example, unnecessary surgery performed on a woman for removal of her breast (mastectomy) after incorrectly diagnosing cancer of the breast renders the doctor liable for negligence (Lewis 1988:272).

Performing surgery on one healthy part of the body when surgery was intended for another part is also a form of negligence eg. operating the healthy right knee, instead of the left knee which needed the operation.

Although surgeons do not guarantee successful outcomes when surgery is performed, the courts hold that it is an inference of negligence, when something untoward happens to a part of the patient's body which should not have been involved in surgery.

More significantly conducting an operation without a patient's or his\her guardian's consent is tantamount to assault and\or battery and consequently renders the doctor liable (Lewis 1988:192). Consent may be expressed or implied, oral or written.

7.13. NEGLIGENCE WITH REGARD TO EQUIPMENT AND FOREIGN OBJECTS

A fertile field for negligence suits is that of obstetrics and gynaecology, where the doctor is necessarily involved with two patients simultaneously. Several cases of brain and spinal damage have been caused as a result of negligent use of forceps during delivery. In these cases either the mother or the baby's guardian has a right to sue (Borten and Friedman 1990:5).

Foreign objects such as swabs and needles which are left in patients' bodies after surgery and which subsequently result in complications, have often been the subject of legal suits, particularly against gynaecologists and obstetricians. (Strauss 1980:272; Lewis 1988:274). According to South African and English cases (van Wyk v Lewis 1924 AD 438; Mahon v Osborne 1939 2KB14) the issue was often the distinction between the liability of the surgeon and that of the hospital for negligence of its nursing staff.

7.14. ACTIONS FORESEEABLE BY PRACTITIONERS

A psychiatrist may be liable for negligent treatment, if a patient commits suicide and such a possibility should have been foreseen. The concept of "due care" in treatment requires the prevention of the opportunity.

Failure to properly supervise a patient, who is dangerous to himself and/or others, may also be a cause for negligence against the hospital or the psychiatrist.

Medical negligence may also include a failure to protect either the patient or a third party from a contagious disease. Although saving an innocent third party from physical harm or from contracting a communciable disease, by disclosing confidential information, may constitute a breach of the rule of confidentiality, it may be justifiably argued in these instances, that it is a greater moral ethic to save life and limb than to observe a professional rule of silence and allow an innocent third party to be harmed (Burchell, Milton and Burchell 1983:335).

It may be argued further, that a timeous warning to a third party by the doctor, prevents the patient from perpetrating the intended criminal act against the third party and accordingly saves the patient from the serious consequences of the act, namely being incarcerated for perpetrating a wrongful act. Taitz (1990:31) submits that from a purely legal point of view, a practitioner faced with an action for damages under these circumstances may have a strong defence in a plea of necessity.

Moreover, the SAMDC's recently issued guidelines (Bulletin of the SAMDC No.6 Sept. 1989) regarding AIDS and medical confidentiality, support the view that saving an innocent life is a greater ethic than breaching the rule of confidentiality.

7.15. INJURIES FROM EQUIPMENT ON PREMISES

Doctors and hospitals are liable for failure to inspect machinery and equipment for obvious defects.

Where a doctor or his assistant is aware that a machine is faulty, he/she must stop using it until it is repaired. Continued use of faulty equipment which causes harm to a patient constitutes negligence. This was established in the case of Bence v Denbo (1970 2 SA :620) where a dentist's X Ray equipment, which had been attached to a wall by a bolt, fell onto the patient's face and severely injured her. It was determined that the bolt had broken. The patient was allowed to recover damages since the court held that the dentist should have inspected his machine.

In Orthopaedic Clinic v Hanson, (LAWSA vol. 2 :991) a technician continued to use an electrotherapy machine, which he knew to be faulty. As a result a patient suffered burns. The court held that the clinic was liable for damages, arising from the fact that the technician failed to shut off the machine and seek assistance.

On the other hand, a patient may not recover damages from a doctor/hospital if an accident resulted from the use of an item of equipment which had a latent defect. (Johnston v Black Company quoted in SAMJ Vol 50:6: 373).

7.16. PATIENTS' DISSATISFACTION WITH DENTURES

As long ago as 1910, the Supreme Court decided in the case of Tulloch v Marsh (1910 TPD 453) that where "a dentist supplies a denture to a patient, the transaction legally amounts to a sale and not to a letting and hiring of services" (Strauss 1980:26). Consequently, the patient (the purchaser) is entitled to reject a patently defective den-

ture, cancel his contract and claim damages for the breach of contract on the part of the dentist, or if he has not paid his fees, then he is entitled not to pay.

In addition, the patient may be entitled to claim recession of the contract or a reduction on its price, should he retain the denture, if the denture has a latent defect. Strauss (1980:27) submits that these remedies are available to the patient even if the dentist did not expressly guarantee the patient satisfaction.

7.17. PHARMACEUTICAL PRODUCTS

If it is conclusively proven, that pharmaceutical products have resulted in injury, defects or death, patients or their dependents, or their guardians may bring an action against the pharmaceutical company that manufactured the drug. However, if the drug had been "interfered with" on route to the dispenser, negligence on the part of the pharmaceutical company must be established in order to hold the company liable for the consequences of its products (Powers & Harris (1990:363).

Powers & Harris (1990:363) have observed that liability for injuries associated with the use of medicinal products represents the type of product liability that engenders not only the most emotive and often misinformed comment but also the most complex questions.

The use of drugs is always attended by risks and their adverse effects are sometimes said to appear many years after its use, or in the offspring of the user rather than in the user herself.

The basis upon which compensation should be claimed could vary according to the nature of the legal relationship between the injured person and those persons in the chain of supply who are instrumental in bringing the product to the consumer. Recently, the European Community has embraced strict liability on the basis that liability without fault on the part of the producer is the sole means of adequately solving the problem of a fair apportionment of the risks inherent in modern technological production (Powers & Harris 1990:364).

The principle underlying fault liability is that

> "it is the duty of every person in the chain of supply of a product to take reasonable care to avoid causing injury to the consumer by his careless act or failure to act, i.e. by his negligence." (Powers & Harris 1990:365).

To succeed under fault liability Borgenhammar (1989:280) submits that

> "the injured person must prove not only that he has been injured by the product and that the relevant person has been negligent but also that for the negligent act the claimant would not have suffered the injury." The burden of proving these elements lies with the claimant and the standard of proof required is the "balance of probabilities".

On the other hand, in the case of strict liability the producer is liable for damage caused by a defect in his product and the injured person must prove the damage, the defect and the causal relationship between the defect and

damage. Most significantly , the person allegedly injured by a defective medicinal product will therefore still have to prove that the injury complained of was, in fact, caused by the product, or the defective nature of the product contributed materially to the injury (Borgenhammar : 1989:280-281).

Where a doctor has been made aware of a patient's adverse reactions to certain drugs but neglects to ascertain this from his records, and injects a person with such drugs (eg. penicillin) he would be liable. However, if the doctor was mistakenly informed by the patient that he was not allergic to a particular drug, the doctor would not be liable, since he had endeavoured to obtain the facts beforehand. Where a patient indicates that he is uncertain of allergic reactions, the doctor's duty is to administer a "scratch test" to establish whether or not the person is allergic. Scratch tests too have been the subject of controversy, since some scratch tests have themselves resulted in serious consequences for the patient (Strauss 1980 :262).

Logically, doctors should administer potentially less harmful products, than undertake the risk of administering potentially fatal products on persons who are uncertain about their tolerance for such medications.

7.18. EUTHANASIA

Active euthanasia, that is, the intentional killing of a patient by a doctor, is a criminal offence, as well as unethical conduct.

Indeed the doctor could be liable for murder (Joubert 1983 : 153). This view is also espoused by the American Medical Association that

> "the intentional termination of the life of one human being by another - mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The

advice and judgement of the physician should be freely available to the patient and/or his immediate family." (Rachels 1991:367)

The distinction between active and passive euthanasia assists in formulating a framework for medical ethics. It seems that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient (Rachels 1991:367).

The distinction between active and passive euthanasia is still a contentious issue eliciting emotive rhetoric from different schools of thought. Nevertheless, Strauss (1987:23) points out that negligent killing of a patient may be punishable as culpable homicide and may also lead to civil liability. It also constitutes unethical conduct. Joubert (1983 :154) submits that "it is lawful to terminate treatment in hopeless cases after all possible procedures have failed, so as to allow the patient to die." In such circumstances the decision should be taken in conjunction with the patient and his family.

7.19. CONCLUSIONS

Consumer information is an important element of consumer protection but in the medical service and product industry meaningful and adequate information to the consumer is often sadly lacking. Suppliers in the medical service and product industry have a virtual monopoly of information which they often fail to share.

It has become apparent that professional disciplinary actions in South Africa do not always adequately protect the legitimate interests of consumers. The deterrent element needs, perhaps, to be reinforced by rules regarding compensation.

Although consumers have the right to institute legal actions against medical professionals, many onerous practical barriers discourage consumers from doing so. The most striking obstacle is the onus of proof which must be discharged by the consumer, who must have a medical professional to testify on his behalf. Most medical professionals are not prepared to risk their established camaraderie nor do they

desire to "waste" time which could be more lucratively spent in their own practices, by testifying in lengthy courtroom cases. The alleged "conspiracy of silence" among the medical fraternity only serves to perpetuate the difficulties within the existing health care system. However, it has been submitted in a case by the House of Lords in Britain that the traditional rule of assessing negligence by the standard of competent medical opinion need not necessarily apply in all cases. Lord Scarmen, in his dissenting speech, remarked that this view of the law was disturbing because it left the determination of a legal duty to the judgement of doctors (South African Medical Journal 1985 Vol.67 No. 25:993).

As regards the onus of proof in respect of medical products, Borgenhammer (1989:281) feels that the legal situation should be such that the victim has only to prove that he has suffered damage and that the damage was caused by the product. The victim need not prove negligence by the producer, nor that the product was defective. This reversal of the traditional principle of liability based on malicious intent and negligence stems from the inequality that exists

between purchasers and sellers of medical products and from the fact that the producer claims to know the characteristic traits of his product. Since the manufacturer can more easily prove the absence of a defect than the victim can prove its existence. This is the basis of strict product liability, which is not based upon fault or negligence, but upon launching a product, which does not provide the safety that one could legitimately expect.

Although one may be tempted to suggest that the reversal of the onus of proof should be extended to the providers of medical services as well, this may lead to unprecedented complications in both the medical and legal systems.

The material presented thus far suggests that the potential for dissatisfaction amongst consumers of medical services and products is high, especially in the complex medical system that exists in South Africa. Consequently, a normative model of patient satisfaction will be developed in the next chapter. Its tenability will be assessed on the basis of an analysis of the empirical study which will follow.

CHAPTER 8

NORMATIVE MODEL OF PATIENT SATISFACTION

8.1 INTRODUCTION

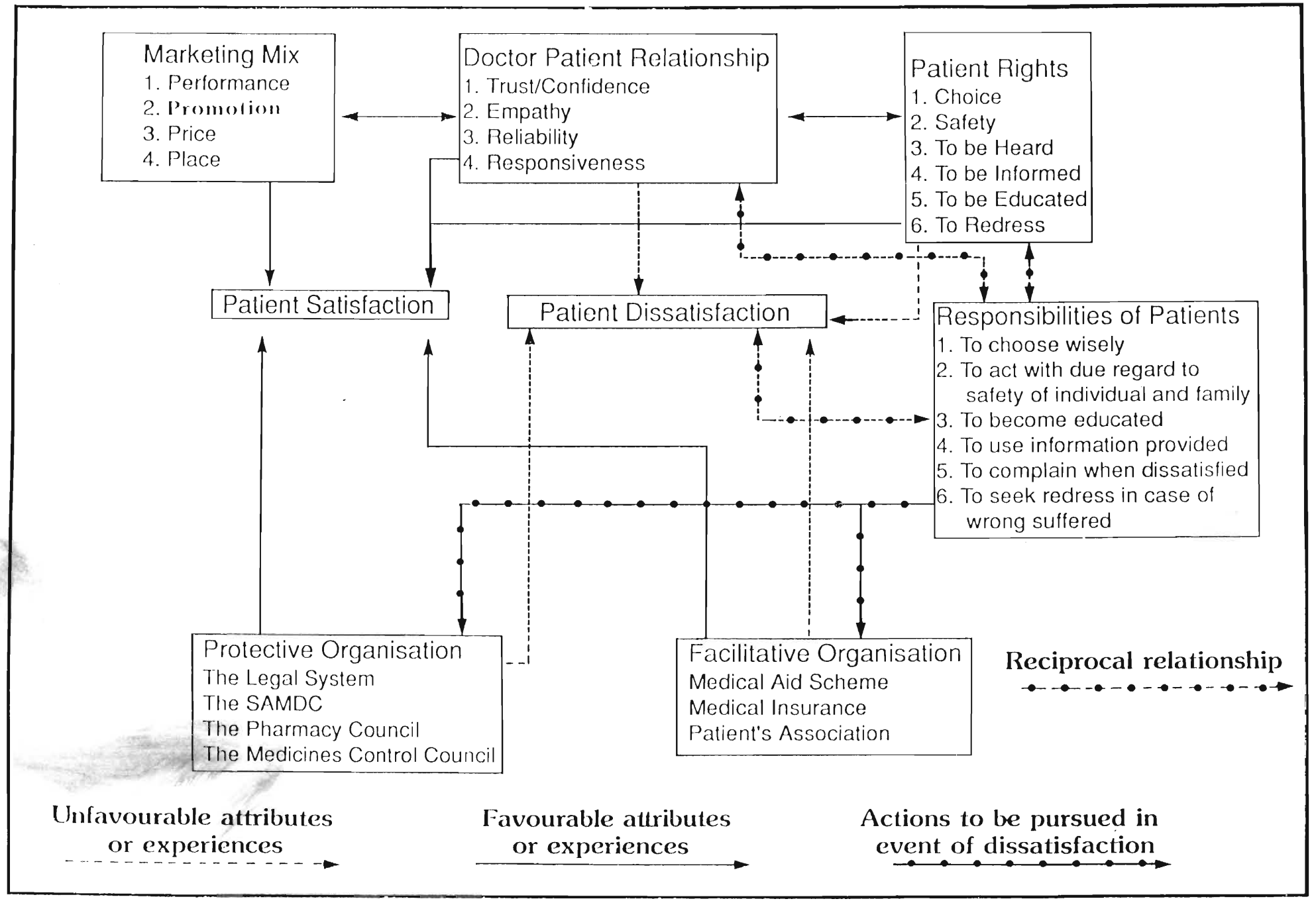
It has become evident from the analyses of the preceding chapters that private patient satisfaction is dependent upon a constellation of interdependent and interacting variables. However, no established measurement scales appear to be available for most of the constructs examined in this study, as a result of a paucity of empirical research in this field. Moreover there appears to be difficulties inherent in delineating and measuring the constructs of service quality models. Accordingly a normative model of the determinants of private patient satisfaction will be suggested against the theoretical background of the preceding chapters. The tenability of this model will be assessed upon an analysis of the empirical study which follows.

8.2 DETERMINANTS OF PATIENT SATISFACTION

The model of patient satisfaction relies on an adaptation of Westbrook's (1981:70) definition of satisfaction as a positive/pleasant "emotional state that occurs in response to an evaluation of interaction experiences."

Although some of the variables depicted in this model (Figure 8.1) are cast as reciprocal constructs, each is nevertheless subject to a variety of interdependent and interacting influences.

FIGURE 8.1 : THE PRIVATE PATIENT SATISFACTION MODEL



Some of the variables are controllable by the providers of medical care, to the extent that they may be integrated, co-ordinated and adjusted in order to satisfy their patients. These controllable variables or antecedents are the marketing mix and the doctor-patient relationship.

Other antecedents of significance are: the acknowledgement of patients' rights by the medical sector, the assistance of facilitative organisations and the existence of protective institutions.

Favourable outcomes with regard to these antecedents contribute to the consequence of patient satisfaction. Unfavourable outcomes among one or more of these antecedents produce patient dissatisfaction.

The model may be symbolically expressed thus:
Patient satisfaction is a function of favourable outcomes in respect of Patients' Rights (PR), the Marketing Mix (MM), the Doctor-Patient Relationship (DPR), (the assistance of) Facilitative Organisations (FO) and (the existence of) Protective Institutions (PI);

i.e. PS = f(PR + MM + DPR + FO + PI) (where f is a function of)

These constructs are described below.

It must be noted that "patient's responsibilities" in deriving satisfaction is cast as a reciprocal concept; i.e. the perception that patients who do not engage in actions that reciprocate the relationship among the participants, may be viewed as dysfunctional in the model.

8.2.1 Patients' Rights and Responsibilities

An acknowledgement of patients' rights and their concomitant responsibilities is an important step towards judicious assessments and legitimate expectations of performance quality. Indeed, these rights and responsibilities ought to be applicable in any system of medical care, whether it is a national health service, a state-subsidized service, a privatized service or any combination of these. The rights to be specified below have already been acknowledged by the General Assembly of the United Nations (See Appendix D) in respect of commercial products and services. They need to be

extended to the medical product and services sector as well, particularly in privatized health care delivery which appears to be rapidly progressing along the entrepreneurial route.

8.2.1.1 The Right to Safety

Patients should be assured that medical products will be safe when used as prescribed. Indeed the Proprietary Association of South Africa has drawn up a Bill of Rights for consumers of self-medication which includes the right to safety. A patient's responsibility to act with due care in the use of medication and equipment is fundamental in ensuring this element of safety.

8.2.1.2 The Right to be Informed

Patients must be adequately informed of risks by doctors and drug manufacturers, especially when medications have a tendency to produce side effects which may be dangerous to them. This right too has been acknowledged by the Proprietary Association of South Africa in respect of self-medication.

In the U.K., even the Medical Protection Society advises its members that they:

> "advocate a policy of full and proper communication with patients. In circumstances where errors and complications arise it is proper that objective, factual information with appropriate clinical reassurance is provided. Adequate explanations... assist in reducing fear and uncertainty which may give rise to complaints and claims" (Lewis, 1988:5).

Borgenhammar (1989:284) believes that information about risks that are related to diagnosis and treatment is

> "important for the patient's self-esteem and for the dialogue that is constitutive of good care, characterized by concern and humanistic values. In the normal case, the patient should be given information which is as comprehensive and detailed as the situation requires."

A study conducted by Byrne, Napier and Cuschieri in 1988 (cited in Borgenhammer 1989:285), where 100 patients were interviewed two to five days after their operations, revealed that:

> "Although all the patients were fully aware that they had had an operation, 27 did not know which organ had been operated on, and 44 were unaware of the exact nature of the surgical procedure."

Borgenhammer (1989:285) also confirms that even British radiologists have agreed on advice regarding consent where emphasis is placed on the fact

> "that doctors owe their patients a duty of care when advising about the risks inherent in a procedure just as much as they do when performing the procedure. Any breach of this duty, that is, failure to warn of risks, may result in a doctor becoming liable in negligence."

The question of the extent to which patients should be informed of risks associated with surgical operations was discussed at length in the "Sidaway Case" (Sidaway versus Board of Governors in the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871:HL) in Britain. The House of Lords

rejected Mrs Sidaway's claim on the ground that she was not informed of a 1% risk of damage to the spinal cord, but it was established that a high level of information and consultation is an essential part of good clinical practice. However it is stated that in the USA, "the concept of informed consent is carried to an absurdity where every conceivable complication of a surgical procedure must be explained to the patient before consent is given." (SAMJ 1985: 993). In Canada for example, it was decided that a 10% risk was material whereas a 1% risk was not. In many other countries too, a compromise is made between the two extremes, such that the patient should be provided with information that would enable him/her to make a balanced judgement.

Mason and McCall Smith (1987:157) have however observed that

> "the consent doctrine in the USA resulted in greater sensitivity on the part of the American medical profession to the need to inform patients of the implications of treatment but this positive result has only been achieved at the price of heightened distrust and an increase in the practice of legalistic and defensive medicine."

In an attempt to prevent such a situation arising in South Africa it would be advisable to follow the course proposed by Braham (in Mason and McCall Smith 1987:159), namely that

> "it is up to us to persuade doctors to alter their practice so as to divulge more information routinely and bring their standards up to what a prudent patient would like to know without intervention of law."

Ideally patients should also be informed of the possible risks of surgery or treatment before they consent to such procedures. The patient's responsibility would be to make attempts to acquaint himself/herself with pertinent information in order to prevent the occurrence of conditions hazardous to his/her health or safety. Patients should also have the right to be informed about the merits of their doctors and specialists, especially with regard to their expertise and qualifications.

8.2.1.3 The Right to Choose

Since patients have limited knowledge about surgical procedures, diseases and medicines, they cannot effectively exercise a choice in terms of what is suitable for their needs. This is done by their doctors or pharmacists. However, with regard to self-medication which is advertised widely, they may exercise some choice, in respect of brands and distribution outlets. Patients should also have the right to choose their general practitioners and specialists. However, this choice is restricted because of the prohibition of advertising by doctors in South Africa, resulting in a lack of knowledge about doctors, their qualifications and their speciality. The responsibility associated with this right should be exercised by the patient's choice of other doctors or specialists for second or further opinions should he/she experience dissatisfaction in any manner, with his/her attending doctors.

8.2.1.4 The Right to be Heard

Patients should be given a hearing with regard to problems they encounter with the services rendered or with the products prescribed. Products that produce adverse reactions should be noted and the information should be communicated to the manufacturing company and the Medicines Control Council in order that they may undertake further research to improve upon the product. Responsible patients must avail themselves of this opportunity in order to improve their position vis-a-vis the providers of products and services.

8.2.1.5 The Right to Education

Patients and citizens in general ought to be educated about matters regarding their well-being, so that they may take steps timeously to remedy problematic situations that may develop. Responsible patients and citizens should make concerted efforts to become aware of practices and procedures that would enhance their position within the health care delivery system. Education could contribute towards:- prevention and/or recurrence of diseases, promotion and preserva-

tion of health; assistance in freeing the community from ignorance and misconceptions as well as from an overdependence on the doctor. The doctor himself appears to be pre-eminently suited to this educational task. Among other channels of communication the public media are effective instruments in fulfilling this role.

8.2.1.6 The Right to Redress

This right has various implications because of the very nature of medical products and services and the absence of any guarantees. However, negligence and malpractice constitute grounds for recourse.

In addition, pharmaceutical manufacturers may be liable for damages caused by defective products. Jager (1980:234) points out that

> "In assessing the liability of the manufacturer, regard must be had to the developing process of a new medicine and the statutory requirements for marketing medicines."

In South Africa, no medicine can be sold unless it has been approved and registered by the Medicines Control Council (MCC) which is a statutory body. The MCC is entrusted with the protection of the public against inefficacious, defective and dangerous medicines, as well as against misrepresentations regarding the therapeutic effects of any specified medicine.

Since the Proprietary Association has also included the right to efficacy for self medication, it is logical to assume that should such products not be efficacious, then the patient should have the right to recourse, either in the form of a refund or a substitute, or else this right falls away.

The responsibility of the patient lies in pursuing those actions that would redress the wrongs suffered. Although a lack of finance can be viewed as a severely restricting factor in the pursuance of some courses of action, such as litigation against doctors, other avenues of recourse should be made available in the interests of equity. Regulatory councils are

in existence but their roles are criticized. Thus there is a need for a voluntary association that can serve the patient in a protective capacity.

8.2.2 Protection of the Patient

Owing to a great informational chasm that exists between the doctor and the patient, a need exists for the protection of the patient. The South African Medical and Dental Council (SAMDC), the Pharmacy Council and the Medicines Control Council have been established, with this objective as one of the basic considerations. However, the procedures involved in redressing issues, especially with the SAMDC are often perceived to be cumbersome and inadequate. Thus the need exists to probe the perceptions of patients in this regard.

Litigation as a form of recourse is costly and assumes two forms, viz. a contractual action and a delictual action. Patients may bring an action on the basis of a breach of contract or on the basis of damages suffered as a result of negligence on the part of the doctor or pharmaceutical company.

The process of litigation as may be recalled from chapters 6 and 7 is very onerous indeed. Against these procedural difficulties, patients' attempts at recourse will be analysed in this empirical survey as well.

8.2.3 Facilitative Organisations

Facilitative organisations usually exist to assist patients who may experience difficulties in various avenues. In privatized medical care, financing is a fundamental concern. In response to this, financial facilitating organisations were established. With regard to other problems, however there appears to be no voluntary association such as a patients' association which could serve as an avenue for the negotiative and communicative processes. The necessity of these organizations as constructs of the normative model are examined briefly.

8.2.3.1 Financial Organisations

8.2.3.1.1 Medical Aid Schemes

Medical Aid Schemes which are registered in terms of the Medical Schemes Act No.2 of 1967 were established with the objective of assisting members with their medical expenses. Employees and employers contribute a predetermined amount on a regular basis irrespective of whether the employee wishes to be a member or not. In most cases medical aid schemes provide only for the economically active and their dependents. In some instances retired persons who were members of schemes before retirement may continue to be members for a stipulated fee. However, medical aid schemes have, at times, been criticised for inefficient claims management and inadequate safeguards against fraudulent claims.

Indeed Ross (1988:23) submits that third party reimbursement leads to greater and perhaps unnecessary use of health care.

> "When a third party pays for a service, consumption and the act of paying are separated in time and place. The consumer is not aware of the cost of the service. There

is little incentive for consumers or providers of services to be cost conscious and herein lies the biggest issue of the health care problem."

In an attempt to curtail this problem amendments to the regulations of the Medical Schemes Act were affected in 1989, which created an avenue for medical schemes to introduce no-claim and low claim bonuses (Annual Report of the Registrar of Medical Schemes. 22/03/91 : 2). The Registrar submitted though, that only a few schemes have offered such bonuses to their members.

The Registrar of Medical Schemes also submitted that there was until 1989 no incentive for either the consumer or the supplier of health care services to be prudent or thrifty. He added that "according to the International Federation of Health Funds, South Africans are amongst the highest claimers in the world". (Annual Report of the Registrar of Medical Scheme 22/03/91 : 10).

In addition, present legislative restrictions on medical schemes, render the introduction of flexible and market-related benefits difficult. Medical aid schemes should be viewed by patients as organisations that facilitate the procurement of private health care. Membership of a particular scheme should ideally be left to the discretion of the individual but in most cases in South Africa membership of a particular scheme is a condition of service. Medical aid schemes do attempt to negotiate reasonable fees on behalf of patients and a Scale of Benefits is proposed which "contracted-in" doctors subscribe to. However, there appears to be an increasing number of doctors who have "contracted-out" and who are implementing the Masa tariffs which are much higher, only partly reimbursable from medical aid schemes and accordingly more burdensome for patients. Consequently the need exists to determine whether patients are indeed experiencing difficulty in discharging their accounts, perhaps by looking to other sources of financing.

8.2.3.1.2. Health Insurance

Health insurance, which may be individually tailored to the needs of the patient, is not bound by the Medical Schemes Act and is being viewed as a challenge to the medical schemes.

The success of health insurance policies appears to depend largely upon the perception of patients with regard to their effectiveness as a means of procuring private medical care.

Health insurance policies appear to be more flexible in application than medical schemes. They are designed to either supplement the benefits of medical aid schemes or to assist those who have no other financial cover. They tend to focus particularly on the funding of hospitalisation and major surgery, accidents or protracted illnesses, as well as the financing of nursing or home care. Its rate of acceptance by private patients will be assessed in this study.

8.2.3.2. A Patients' Association

A voluntary independent patient's association that would facilitate the communicative and negotiative processes between patients and doctors is absent in South Africa. But it is perceived as being desirable, especially in view of the formidable medical professional associations that exist to foster the interests of the medical profession. By contrast, Britain has a well established patient's association despite the fact that a national health service predominates in that country.

The need for a patient's association appears to be more relevant in an environment where procedural difficulties abound in attempting to redress dissatisfactions, negligence or malpractice. Such an association could facilitate an improvement in the informational, educational and protective aspects of patients. The desirability of such an association from patients' points of view will also be probed in this study.

Other constructs that are considered to be significant in contributing to patient satisfaction are the elements of the marketing mix utilised by medical service providers.

8.2.4. Service Marketing Mix

8.2.4.1. Price

Competitive pricing of services is virtually non-existent in this highly regulated industry. Individual patients whose main concern is regaining their health, are not in a position to bargain over prices. Moreover, membership of medical aid schemes provides no incentive to do so. However, there appears to be dissatisfaction among patients with regard to their inability to influence pricing decisions, especially in view of the increasing number of doctors who have "contracted-out" of the medical aid schemes and who expect their higher fees to be paid directly by patients.

It is suggested that a more flexible pricing policy be permitted and that doctors be allowed to advertise their rates for each consultation and/or form of treatment.

8.2.4.2. Place

Private medical practitioners have in the past two decades tended to locate their practices in medical centres or clinics in CBD areas. These centres are considered to be "catchment" areas for patients. For those living outside the CBD areas, place utility is at a premium, especially in the case of emergencies. Although it is argued that one-stop medical care facilities at medical centres solve the problem of searching for specialists in different areas, it compounds the problem of overservicing, since medical professionals are often major shareholders in these centres, and its profitable perpetuity appears to be of some concern to them.

The establishment of clinics in strategic areas with a number of specialists who could consult with each other in determining holistic care for patients, would obviate the problem of overservicing and misdiagnosis. Private practitioners interested in serving rural communities could do so in mobile

clinics. Emergency treatment throughout the day and night could also be ensured if practitioners arrange to work on a "shift" basis.

8.2.4.3. Promotion

Promotion in the media is not currently a marketing mix option for medical practitioners in South Africa, since it is frowned upon and indeed prohibited by the South African Medical and Dental Council except in instances where information is deemed to be of interest to the community at large.

In contrast however, in the late 1970's, (in the USA) members of the government viewed the banning of advertising as a means to limit competition and therefore declared the professional codes which discouraged advertising, as illegal (Labarbera & Reddy 1987:43).

However studies conducted in America, after the ban was lifted, revealed that the majority of medical professionals believed that advertising would not help consumers to make

more intelligent physician choice, but the majority of consumers on the other hand believed that advertising would help them to make intelligent choices of physicians.

Health care is viewed as a commodity - a very expensive commodity - because of the entrepreneurial nature of the US health care sector. Consequently consumers believe that they should be afforded an opportunity of making their own decisions as to who will attend to their health care needs.

The South African consumer should also be given the opportunity of making an intelligent choice of his/her doctor.

The South African Medical & Dental Council, in its attempt to protect the patient, presumes that the patient is not sufficiently knowledgeable in assessing the credibility of promotional efforts by practitioners. It must be pointed out that direct communication by practitioners with regard to their specialities, qualifications, success rates, fee structures and consultation policies during emergencies could sig-

nificantly impact upon the patient's decision making process. The perception of patients in this regard also needs to be probed in this study.

8.2.4.4. Performance of Services

Medical services involve simultaneous production and consumption. Moreover they do not have form utility but they do have performance utility. The qualitative element is the overriding factor in determining a measure of the practitioner's performance productivity, which ultimately determines the dimension of satisfaction that patients derive.

Many of the elements that contribute to patient satisfaction are controllable at the point of interaction between doctors and their patients. These controllable antecedents influence patient evaluations and perceptions of service quality. Research suggests that variations in controllable variables can affect perceptions of an experience independently of the actual outcome (Bitner 1990 : 72). For example, where a doctor's treatment per se may be considered to be excellent,

the circumstances pertaining to the delivery of that service, such as untidy waiting rooms and unpleasant staff may be perceived as being undesirable.

Parasuraman, Ziethaml and Berry (1988:23) have also identified five dimensions of service quality (SERVQUAL : a multiple item scale for measuring consumer perceptions of service quality). These dimensions which should ideally feature as integral components of medical services are:

"Tangibles : Physical facilities, equipment and appearance of personnel.

Reliability: Ability to perform the promised service dependably and accurately.

Responsiveness: Willingness to help customers and provide prompt service.

Assurance : Knowledge and courtesy of employees and their ability to inspire trust and confidence.

Empathy : Caring, individualised attention the firm provides its customers."

Bitner (1990 : 70) also postulates that because of distinguishing characteristics of services, service firms have additional variables beyond the traditional "4P's" that can satisfy target markets. For example, because services are produced and consumed simultaneously, customers are often present "in the firm's factory" and interact directly with the firm's personnel.

Consequently in a medical practice, the doctor and his staff play marketing roles as well as provide valuable operational functions. Bitner, adds that "because services are essentially intangible processes, customers are frequently searching for surrogates or 'cues' to help them determine the firms capabilities." Thus the patients' cues may be, inter alia, the waiting room, the types of equipment used, the degree of care rendered by supporting staff, efficiency and general bedside manners. There appears to be no doubt therefore, that service satisfaction and service quality are nested within peripheral issues as well.

Although service satisfaction or service quality defy rigid definition, it can be operationally defined within the context of the disconfirmation of expectations paradigm as explained by Bitner (1990 : 70). "The theory underlying this paradigm is that consumers reach satisfaction decisions by comparing product or service performance with prior expectations about how the product or service would or should perform. Each individual consumer is assumed to have expectations about how each individual service/product will perform. These expectations are compared with actual perceptions of performance as the service is being received. If expectations exceed performance, dissatisfaction results. When expectations are met or exceeded, satisfaction results. Parasuraman, Ziethaml and Berry (1985 : 44) are also of the opinion that patient satisfaction depends directly on the management and monitoring of individual service encounters.

Invariably service encounters represent a crystalization of the Marketing Mix of the provider of a service. Accordingly factors that positively influence service evaluations ought to be critical to these providers.

It must be pointed out that the dynamic, sometimes complex, role performed by doctors over time, increases the importance of the customer's perceptions and evaluation of his efforts to manage their relationship; especially since interactions between doctor and patient tend to be recurring rather than single encounters.

Thus anticipated levels of satisfaction or performance are likely to affect the patient's decision of whether or not a particular doctor's services should be retained or substituted. Accordingly the long term interests of the patient may be best served by initiating and maintaining an enduring relationship.

8.2.5 Doctor-Patient Relationship

Trust and faith in the practitioner as well as confidence in his consistently satisfactory performances in the past may imply that the patient will rely on the practitioners' integrity and expertise for future performances as well. The patients' best assurance of satisfaction is a continuous error-free interaction.

The patient's perception of the practitioner's dynamic and complex yet well performed role in a multifaceted relationship over time, enhances the evaluation of the practitioner and results in satisfaction.

Trust and faith are particularly important where uncertainty prevails; where risks in procedures are inherent and where contracts of guarantees are non-existent.

In order to evaluate the tenability of this normative model it is now necessary to formulate the underlying hypotheses which will be statistically tested in the empirical study which follows. It should be noted that formulations are specified in null hypothesis terms together with the alternative hypothesis which would become relevant in the event of rejection of the null hypothesis. It is expected that the null hypotheses will in fact be rejected in the study.

8.3. RESEARCH HYPOTHESES

8.3.1. The Central Null Hypothesis

Consumers of private medical products and services are satisfied with the present system of private medical care.

Alternate : Consumers of private medical products and services are dissatisfied with the present system of private medical care.

8.3.2. Subsidiary Null Hypotheses

H1 The majority of residents in the Durban Magisterial District do not receive private medical care.

Alternate: The majority of residents in the Durban Magisterial District receive private medical care.

H2 Medical consumers are opposed to the establishment of a National Health Service.

Alternate: Consumers would prefer the establishment of a National Health Service.

H3 The use of private medical care is not related to medical aid membership.

Alternate: The use of private medical care is positively related to medical aid membership.

H4 Private medical consumers are satisfied with services provided by private practitioners.

Alternate: Private medical consumers are dissatisfied with services provided by private practitioners.

H5 Private medical consumers would avoid state facilities even if there were an improvement in the methods of delivery of public medical care.

Alternate: Private medical consumers would utilize state facilities if there were an improvement in the methods of delivery of state subsidized medical care.

H6 Medical consumers believe that the main purpose of private practitioners is profit maximization.

Alternate: Medical consumers do not believe that the main purpose of private practitioners is profit maximization.

H7 Medical aid members believe that medical aid membership is not necessary in order to receive private medical care.

Alternate: Medical aid members believe that medical aid membership is necessary in order to receive private medical care.

H8 Medical aid members do not believe that medical aid schemes are being abused by members.

Alternate: Medical aid members believe that medical aid schemes are being abused by members.

H9 Medical aid members do not believe that medical aid schemes are being abused by doctors.

Alternate: Medical aid members believe that medical aid schemes are being abused by doctors.

H10 Medical aid members believe that medical aid schemes do not result in higher costs of medical care.

Alternate: Medical aid members believe that medical aid schemes result in higher costs of medical care.

H11 Members of medical aid schemes would not visit their practitioners less often if they were not members of medical aid schemes.

Alternate: Members of medical aid schemes would visit their practitioners less often even if they were not members of medical aid schemes.

H12 Medical aid schemes provide adequate financial cover for the needs of their members.

Alternate: Medical aid schemes do not provide adequate financial cover for the needs of their members.

H13 Medical aid members regard medical aid schemes as their representative organisations.

Alternate: Medical aid members do not regard medical aid schemes as their representative organisations.

H14 Medical consumers would not support the establishment of a Patient's Association.

Alternate: Medical consumers would support the establishment of a patient's association.

H15 Medical Consumers do not consider the cost of private medical care to be excessive.

Alternate: Medical consumers consider the cost of private medical care to be excessive.

H16 Private medical consumers do not believe that doctor's fees should be based on a number of different factors.

Alternate: Private medical consumers believe that doctor's fees should be based on a number of different factors.

H17 Private medical consumers do not have an informed choice with regard to private practitioners.

Alternate: Private medical consumers have an informed choice with regard to private practitioners.

H18 Private medical consumers should not be able to consult specialists without referral by their general practitioners.

Alternate: Private medical consumers should be able to consult specialists without referral by their general practitioners.

H19 Private medical consumers do not complain about their unpleasant medical experiences.

Alternate: Medical consumers always complain about their unpleasant medical experiences.

H20 Private medical consumers believe that the South African Medical and Dental Council protects them adequately through their disciplinary processes.

Alternate: Private medical consumers believe that the South African Medical and Dental Council does not adequately protect patients.

H21 Private medical consumers do not prefer to know about medicines that have been prescribed for them.

Alternate: Private medical consumers prefer to know about medicines that have been prescribed for them.

H22 Doctors and pharmacists do not inform their patients adequately about medication.

Alternate: Doctors and pharmacists inform their patients adequately about medication.

H23 Private medical consumers do not initiate actions to redress problems pertaining to medical products and services.

Alternate: Private medical consumers initiate actions to redress problems pertaining to medical products and services.

H24 Private medical consumers do not believe that they should be allowed to return and be reimbursed for medicines that cause adverse reactions.

Alternate: Private medical consumers believe that they should be allowed to return and be reimbursed for medicines that cause adverse reactions.

H25 Private medical consumers do not believe that doctors should be allowed to advertise.

Alternate: Private medical consumers believe that doctors should be allowed to advertise.

H26 Private medical consumers do not become annoyed when they have to wait for long periods to be attended to, after arriving punctually for their appointments.

Alternate: Private medical consumers become annoyed when they have to wait for long periods after arriving punctually for their appointments.

H27 Private medical consumers can easily consult with their doctors by telephone in order to clarify doubts and obtain results.

Alternate: Private medical consumers have difficulty in clarifying doubts and obtaining test results from their doctors, by telephone.

H28 Private medical consumers do not believe that their practitioners overservice.

Alternate: Private medical consumers believe that their practitioners tend to overservice.

8.4. SUMMARY

Few researchers in South Africa have focused on service quality models because of the difficulties inherent in delineating and measuring the constructs of various services.

However a normative model of the determinants of private patient satisfaction was suggested against the theoretical background of the preceding chapters.

Antecedents which are controllable by practitioners were identified as the marketing mix options and the doctor-patient relationship. Other antecedents which significantly

contribute to the consequence of patient satisfaction were identified as: an acknowledgement of patients' rights by the medical sector; the assistance of facilitative organisations and the existence of protective institutions. The patient's responsibility to address dysfunctional elements in the system in attempting to derive satisfaction, was cast as a reciprocal concept.

The patient satisfaction model presented in figure 8.1. depicts the interrelationships among the antecedents and consequences.

Finally the underlying hypotheses which will be tested in the empirical study were formulated.
Accordingly, the research methodology pertaining to this empirical study will be examined in the next chapter.

CHAPTER 9

RESEARCH METHODOLOGY

9.1 INTRODUCTION

This study focuses on the perceptions of patients who receive medical care from the private medical sector. Private medical care, as suggested in chapter 5, is the treatment received by patients from medical practitioners who have their own practices and who charge a fee which is paid by the patient and/or a medical aid scheme and/or an insurance fund. It is distinguished from the State subsidized health service for which patients pay nominal fees based on their financial capability. In the latter instance, patients receive treatment in primary health care centres, government subsidized clinics and hospitals.

Private medical care appears to be utilized at an increasing rate, apparently because of the great inconvenience that patients presently undergo at State subsidized institutions.

Moreover, it is being made more accessible to the Black population as a result of an increasing rate of membership of medical aid schemes by Blacks.

Together with such increasing private sector patronage, however, there appears to be a growing disenchantment among consumers with regard to their treatment and the circumstances pertaining to their treatment. Moreover, it has become evident that associations which fulfill vital roles in the administration of the private health care system, have neither the responsibility nor the initiative to systematically monitor consumer perceptions. It is also becoming apparent that the delivery of private medical care is assuming an entrepreneurial character, which in itself is eliciting much criticism.

Accordingly, a need exists to empirically probe the existing treatment of consumers, their perceptions of that treatment and their rights to redress within the framework of existing legislation and practice. The area selected for this empirical study was the Durban Magisterial District.

9.2. THE STUDY AREA : THE DURBAN MAGISTERIAL DISTRICT

The Durban Magisterial District consists of Amanzimtoti, Chesterville, the Durban Municipal Area, Isipingo, Kingsburgh, Lamontville, Lower Illovo, Queensburgh and Umbogintwini. This area has been selected for the investigation since it has a sufficiently large household population from which an adequate sample can be chosen.

The population within the Durban Magisterial District has easy access to private medical practitioners who are also situated within the area being studied. It probably has the highest density of private medical practitioners in Natal, as well as the highest density of State employed medical practitioners.

Moreover, a wide variety of population groups and socio-economic conditions exist among the population in this area, which would facilitate cross tabulations and other pertinent analyses based on these factors.

9.3. LIMITATIONS OF THE STUDY

By confining attention to the Durban Magisterial District it is acknowledged, that the perceptions of significant rural populations, who are served by private medical practitioners because of the absence of adequate State subsidized health care facilities are excluded. The perceptions of these patients could affect the general validity of these results in view of the greater problems of accessibility, ability to pay, communication and a greater reliance upon alternative forms of treatment such as the use of witch doctors. To extend this study into rural areas would involve considerable expense: since interpreters would be required in the personal interviewing method because many are not conversant with English. Furthermore research in rural areas involve great risks to interviewers because of the highly unstable conditions that persist in some of these areas at present. However these findings could be reasonably representative of urban populations within South Africa.

9.4. SELECTION OF THE SURVEY METHOD

Survey research is the systematic gathering of data from respondents through questionnaires. Questionnaires may be administered via the mail, by telephone or through the personal interview method. In the selection of an appropriate survey method these three traditional methods as well as one other were considered.

It is logical that when collecting information from respondents, researchers should strive to utilize methods that secure accurate information in the shortest period, with the least cost, while allowing flexibility and minimum supervision. Unfortunately none of the methods considered possess all these characteristics. This necessitated an assessment of the relative strengths and weaknesses of each before an appropriate method was adopted. Nothing precludes the use of more than one survey method at a time, although the cost may become prohibitive.

This study consists of two phases. Phase one addresses the administration of a survey to medical consumers, while phase two deals with the administration of specially designed short questionnaires to various providers of medical products and services, as well as to other participating intermediaries who have an interest in the provision of health care.

Because of the nature of this survey, more than one survey method was utilized. These methods, and the reasons for their adoption are described below.

9.4.1. Telephone Surveys

Telephone surveys are cost effective for getting quick answers to simple, non-personal questions. A good telephone interviewer may vary questions to suit the interviewee and adapt questions according to earlier responses.

Telephone interviewing has increased in popularity because of widespread telephone ownership, the increased cost of personal interviews, and reduction in the problems associated with unlisted numbers, through sophisticated techniques.

The advent of Computer-Assisted Telephone Interviewing (CATI) has further improved the potential for telephone surveys. The CATI system involves programming a survey questionnaire directly into a computer, while the interviewer reads the questions from the screen and records the answers on the terminal keyboard or directly onto the screen with a light pen. (Tull & Hawkins 1984 : 124-125). The computer facilitates flexibility and the creation of an "individualized" questionnaire, as well as speedy analysis. The response rate is fair and supervision over interviewers is easy, especially if interviewers are based in a central facility.

The major drawback of telephone surveys is that the questionnaire must be short and relatively non personal. In this study, neither condition held: the questionnaire would be lengthy and very personal.

9.4.2. Personal Interviews

The personal interview method which is also widely used and which requires an immediate response, was not selected for

phase one of the survey since the responses, ideally, had to be well considered and discussed between spouses to facilitate consistency and recall with regard to their responses. Personal interviews are also costly and time-consuming since the sample units are usually widely dispersed and much travelling needs to be undertaken by interviewers.

Researchers sometimes attempt to reduce cost and time per interview by conducting shopping mall interviews. But this too could not be adopted for phase one of this study for reasons already mentioned.

9.4.3. Mail Surveys

A mail survey involves the mailing of a questionnaire to each potential respondent, usually with instructions and a self-addressed stamped return envelope. The questionnaires are returned upon completion, by mail to the researcher. In a mail survey, the desired respondent is more likely to be reached since more time is available to answer the questionnaire ap-

propriately. Moreover, answers could be well considered and a greater degree of accuracy could be ensured since respondents could review the responses to eliminate inconsistencies.

However, a major drawback of mail surveys is the low response rate. Some researchers attempt to increase the response rate by offering a reward upon the return of the completed questionnaire. This undoubtedly increases the cost of mail surveys.

Mail surveys obviate the great need for survey research validation and monitoring which are essential in the personal interviewing method to ascertain whether interviewer cheating has occurred.

9.4.4. Evaluation of Survey Methods

None of the above methods was considered appropriate for phase one of the survey.

The method which was selected is seldom discussed by authors but is less costly than the personal interviewing method, ensures a considerably higher response rate than mail surveys, permits the researcher to probe personal and confidential questions, and possesses all the merits of a mail survey. This method involves the personal distribution (by research assistants) of questionnaires to desired respondents who are given a specified period within which to complete the questionnaire at their convenience. This also provides an opportunity for well considered responses.

The completed questionnaires are then collected by the assistants after the stipulated period and forwarded to the researcher. A degree of anonymity may be ensured if no names are requested on the questionnaire.

This method was furthermore selected because it was felt that the nature of the questions were such that respondents would have been interested enough to complete the questionnaire personally: health issues affect every individual and responsible individuals would be interested in an envisaged improvement in the status of the present system of private medical care.

With regard to phase two of the survey, however, different methods were employed to elicit the responses of the providers and facilitators in the health care sector. Telephone surveys, personal interviews and interviews through the telefax method were adopted as a result of such requests from the desired respondents. Moreover, questionnaires were designed to suit the various types of respondents, resulting in many different interview schedules for different categories of respondents.

9.5. THE SAMPLING PROCEDURE

Sampling is an essential element in research design since considerations of cost, and time constraints make it impractical to take a census.

Although sampling may involve sampling errors, representative samples may substantially reduce the nonsampling errors in a sample relative to those in a census. Indeed, Tull & Hawkins (1984 : 378) assert that "the nonsampling errors can often be reduced to the point at which the sum of the sampling and nonsampling errors of the sample are less than the nonsampling

error alone in the census. When this is the case, it is possible to obtain a more accurate measurement from a sample than from a census."

Samples may be divided into two categories, namely probability samples and non-probability samples. A probability sample is chosen such that each member of the universe has a known chance of being selected, that is the sample is objectively selected while in a non-probability sample, the chance of any particular unit in the population being selected is unknown, that is, the sample is subjectively selected. The random sampling method was selected for phase one of this survey and for parts of phase two.

9.5.1. Defining the Population

The population in phase one of this study is defined as households in the Durban Magisterial District.

Households are basic units in society and may vary in size. It usually consists of a household head, the spouse and dependent family members.

The population in phase two consists of private practitioners, medical professionals in academic institutions, professional association representatives, representatives of statutory control councils, pharmaceutical manufacturers, representatives of medical aid schemes as well as some attorneys who are perceived to be experts in medical litigation.

9.5.2. The Sampling Frame

A sampling frame is a means of representing the units of a population, such as a telephone directory, an employee roster or student enrolment list. A sampling frame is a prerequisite for extraction of probability samples.

Perfect sampling frames, in which every element of the population is represented once only, are rare; therefore researchers utilize the best possible frames and acknowledge frame errors in their studies.

The most widely used frame for sampling human populations is the telephone directory, although it must be conceded that the distribution of telephone ownership is not even across all groups of people. Additionally many homes with telephones do not have their numbers listed in the directory.

A sampling frame which contained a list of addresses was desired in the first phase of this study, since assistants were required to distribute questionnaires to the households which were randomly selected from the list contained in the 1990/1991 Durban telephone directory. Only those households that were located within the Durban Magisterial District were selected.

In the second phase of the study too, only private medical practitioners who were located within the Durban Magisterial District were randomly selected from a list of practitioners appearing in the Durban telephone directory.

While pharmaceutical manufacturers were chosen on the basis of their placing on the PMSA list which was kindly provided by one pharmaceutical manufacturer's representative, other respondents were deliberately selected by virtue of their occupational status within the other associations.

9.5.3. THE SAMPLING UNIT

The sampling unit is the basic unit containing the elements of the population to be sampled (Tull & Hawkins : 1984 : 385). The sampling unit of an address is required in mail questionnaires, in - home personal interviews and the personal distribution method. The desired respondent in each household may also be indicated, for example, the researcher who wishes to interview the adult population, must have a random sample of the adult residents of each household. In this survey the adult residents were expected to confer with each other in the completion of the questionnaire.

9.6. THE SAMPLE SIZE

According to latest figures obtained from the various Town Councils within the Durban Magisterial District there were 113 125 households in the study area. Households were decided upon as sampling units with the household head or spouse as the respondent since either or both are usually aware of the health needs of the entire unit and are jointly responsible for the costs thereof.

A sample size of 170 was decided upon in phase one in order to facilitate the computation of statistical tests pertaining to the hypotheses that were formulated. Such a sample size would be adequate for appropriate application of either parametric or non-parametric techniques. 170 households were selected at random. If a household was unoccupied at the time of calling the next door neighbour was approached instead.

In phase two of the study the sample sizes varied in different categories, for example, 25 private practitioners from the Durban Magisterial District were selected, whereas 15 pharmaceutical manufacturers from the whole of RSA were selected,

while others were selected because of their membership of professional associations. In most cases just one member of each association was selected.

Having described the rationale of this study, as well as the sampling procedures selected, it is pertinent at this stage, to explain the statistical techniques that will be employed in the analysis of the data.

9.7. STATISTICAL TESTS

Research is conducted in order to determine the acceptability of hypotheses that have been derived from theories of behaviour. In order to arrive at a decision about a hypothesis, an objective procedure must be selected from alternative statistical lists that are available. Owing to the paucity of prior research in this field, and the absence of evidence to support the assumptions about the patient population, it was decided to employ nonparametric statistical techniques to test the hypothesis. Nonparametric statistics result in "conclusions which require fewer qualifications: (Siegel 1956:3). In addition, some nonparametric tests may focus on

the order or ranking of scores, while others are useful with classificatory data. The different types of tests employed in this analysis is explained below.

9.7.1. The One Sample Test

"The one sample nonparametric test is usually of the goodness-of-fit type. In the typical case, one draws a random sample and then tests the hypothesis that this sample was drawn from a population with a specified distribution. Thus the one sample test can be used to determine whether there is a significant difference between the observed frequency and the expected frequency, or between observed and expected proportions. Usually the chi-square one sample test evaluates the null hypothesis that there is no difference between observed values and expected values.

The formula for the $x^2 = \sum \frac{(Oi-Ei)^2}{Ei}$

where O is observed value and E is the expected value

9.7.2. The Binomial Sign Test

The binomial sign test is employed with data that are in the form of a dichotomous variable. This test is also of the goodness-of-fit type. Generally a frequency distribution of scores on a single sample of subjects "is evaluated with regard to the likelihood of observed frequencies, given *a priori* expected probabilities for the two response categories." (Sheskin 1984:17)

In the case of large samples, extensions of the binomial sign test utilising the normal and chi-square distribution are commonly employed. "When the normal distribution is used, the test is referred to as the normal test or the z-test for a single sample or proportion. When the chi-square distribution is employed, the test is referred to as the chi-square one-sample test and it yields results equivalent to those obtained with the normal test". (Sheskin 1984:17) The formula for this test is

$$Z = \frac{Y - n/2}{\sqrt{\frac{n}{4}}}$$

where Y equals the number of observed signs and n is the sample size.

Where a single random sample is classified on two dimensions, resulting in a two-dimensional contingency table, the chi-square test of independence on r x c contingency tables is employed to evaluate the null hypothesis that the two dimensions are independent of one another, or that the correlation between the two dimensions is zero.

The formula for computing this test is

$$x^2 = \sum \frac{(Oij - Eij)^2}{Eij}$$

with df = degrees of freedom = (r-1)(c-1)

where r = number of rows

c = number of columns

Oij = observed frequency in cell ij.

Eij = expected frequency in cell ij.

9.7.3. Measures of Correlation/Association

In general, measures of association/correlation are employed to test the hypotheses that:

i) In the case of the Null Hypothesis (Ho); the true association/correlation between the populations (or conditions) equals zero;

ii) In the case of the Alternate Hypothesis, Hi, the true association between the populations (or conditions) equals some value other than zero, up to 1.

The Contingency Coefficient $C = \sqrt{\frac{x^2}{x^2 + n}}$

(Freund & Williams 1977:343)

The application of objective statistical tests to the data acquired during the survey enables one to assess whether or not the results were likely to have occurred by chance.

It is also essential to indicate the level of significance for the statistical tests to be employed.

The 0,05 level of significance, which is less stringent than the 0,01 level was selected as the level of significance for all the relevant tests, unless otherwise stated.

9.8. CONSTRUCTION OF THE QUESTIONNAIRE

A questionnaire is a formal list of questions designed to elicit responses from desired respondents on a given topic. It is the major instrument used in obtaining primary data from respondents through the survey method.

A non-disguised questionnaire which reveals the purpose of the study to the respondent was used in both phases of this survey. The questions ranged from the structured form in phase one to the unstructured form in phase two.

Structured questions which are synonomous with closed-ended predetermined choices are presented to every respondent. It obliges respondents to choose the most appropriate alterna-

tives. The researcher is also expected to include as many alternatives as possible in order to derive a meaningful response. Some researchers include an "other" specify alternative to include every possible option, which may be categorised after the questionnaires have been received. The advantages of structured questionnaires are ease of administration, computation and tabulation by the researcher, as well as speed in analysis.

Open ended or unstructured questions generate a variety of responses which may be as large as the sample size itself, consumes more time and is difficult to tabulate.

In view of the large sample size and the complex nature of phase one of the survey, only structured questions were posed to medical consumers, while open-ended questions were posed to the participants and facilitators in the medical sector. The sample size was small enough in each of the cases of phase two of the survey and the questions were few and simple, but the responses were expected to be detailed.

9.8.1 The Questionnaire

A total of 58 structured questions were posed to respondents. A copy of the questionnaire is included as Appendix G. The reasons for posing each of the questions will be discussed and the statistical tests to be utilised in testing the hypotheses will be specified.

Questions 1-10 address the system of delivery of medical treatment, the preference for either or both systems and the reasons for satisfaction or dissatisfaction of the system utilised.

Question 1 addresses the null hypothesis that the majority of households in the Durban Magisterial District do not receive private medical care. The binomial large sample sign test will be adopted to test this hypothesis. It is expected that some respondents would receive treatment from both private and State subsidised facilities, since nothing prohibits them from doing so. Those who fall in this category and use private medical care to a greater extent than state subsidised facilities would also be considered as private consumers.

Question 2 probes the preference for the system of health care delivery in South Africa in the absence of a National Health Service.

Question 3 pertains to the null hypothesis that consumers do not prefer a National Health Service (NHS). Since it was expected that some consumers would not know what a National Health Service is, a brief explanation of it was furnished in this question. This question probes the preference for a system of delivery of health care, which is presently being debated among the government, health authorities and other interested parties. The large sample sign test will be implemented to determine whether yes answers for the establishment of an NHS will predominate, since the acceptance or rejection of this null hypothesis depends on yes and no responses.

A correlation coefficient test may be employed to test the relationship among the respondents in various income levels and their preference for a particular system of health care delivery.

Question 4

Answers to question 4 would reflect the reasons for the use of private medical facilities.

Question 5 relates to the central null hypothesis viz. that consumers of private medical products and services are not dissatisfied with the present system of private medical care. Since this question could elicit three categories of responses, the chi-square test would be employed to test this hypothesis.

Answers to question 6 would reflect the variety of reasons for dissatisfaction while answers to question 7 would reflect the variety of reasons for the respondent's satisfaction. It would be possible to ordinally rank these responses in both questions for each of the categories namely family doctor, specialist and hospital. Cross tabulations will be used to indicate the relationship among the variables.

Question 8 addresses the null hypothesis that there would not be an increase in public sector usage even if there were an improvement in the method of public medical care delivery. The

large sample sign test would be implemented to test this hypothesis as well. Reasons for yes and no responses would also be provided to explain the decision taken.

Reasons for the use of State subsidised facilities, are probed in question 9.

Answers to question 10a would reflect the variety of reasons for dissatisfaction among users of State subsidised facilities, while question 10b reflects the reasons for satisfaction among users of state subsidised facilities.

Question 11 reflects the perception of consumers with regard to the reason for the existence of private practitioners. Their perceptions may indicate whether they view private practitioners as entrepreneurs or as socially responsible professionals whose main interest is the welfare of the population.

Questions 12-14 relate to medical aid schemes, the consumer's perceptions of the medical aid schemes and several null hypothesis. Question 14 addresses the various null hypotheses pertaining to medical aid schemes. These hypotheses will be

either accepted or rejected on the basis of the implementation of the binomial large sample sign test. Question 12 also probes membership of medical insurance policies and the extent to which members of medical aid schemes also accept insurance policies as well. Question 13 addresses the null hypothesis that consumers would not visit their practitioners less often if they were not members of medical aid schemes. The binomial sign test would also be used to either accept or reject the hypothesis.

Question 15 probes the desirability of a Patient's Association among medical consumers.

Question 16a pertains to the perceived cost of private health care and consequently addresses the hypothesis that consumers consider the cost of private health care to be excessive. Chi-squared tests would be employed to test the perceptions of lower income groups and higher income groups. The income classes would be ascertained from Question 56.

Question 16b and 17 address the issue of pricing flexibility on the part of the doctor.

Question 18-42 address issues pertaining to the rights and responsibilities of private medical consumers as suggested in Chapter 5. Question 18-20 pertain to the issue of the right to an informed choice in respect of private practitioners, and the sources of their information given the fact that the profession itself is prohibited from providing any information about themselves or their specialities. These questions relate to the null hypothesis that consumers have an informed choice with regard to their doctors. The chi-square sign test would be implemented to validate this hypothesis.

Question 21 to 22 pertain to the medical consumer's right to choose. This right is severely restricted because of the limited information available and because of rules laid down by medical aid schemes in respect of treatment by specialists.

Questions 23-25 relate to the medical consumer's right to be heard and his/her concomitant responsibility of pursuing a course of action in this regard. Question 23 also addresses the null hypothesis that patients do not discuss their un-

pleasant medical experiences with friends and family. The Chi-square test will be employed to either accept or reject the hypothesis.

Questions 27-32 address the delicate and subtle relationship between the doctor and the patient, and investigates the patient's awareness of what course he/she may follow when problems arise between doctor and patient, and where the doctor is viewed as acting contrary to professional ethics. The yes and no responses to question 28b will facilitate the implementation of the large sample sign test. These results would determine whether the hypothesis, that the SAMDC protects patients adequately through their disciplinary process, will be accepted or rejected.

Question 31 also relates to the hypothesis that victims of malpractice actions sue their doctors for damages. The large sample sign test would also be implemented here. A correlation coefficient test may be employed to test the responses in question 31 and 32 to determine whether victims who sue for malpractice are successful or not.

Questions 33-35 relate to the medical consumer's right to be informed. The decision as to what information should be provided to the patient is more difficult to arrive at, than that which should be provided to the consumer of goods. The reasons are varied and may include the fact that non-disclosure of a possible adverse situation that may or may not materialize, when medical products are used, may be less harmful to a patient than the disclosure itself which may cause the patient to be afraid and risk not using the medication/treatment, when it could help him/her. The consumer's reasons for wanting to be informed of what he/she is taking, may be gauged from question 34.

Question 36 provides an opportunity to implement the chi-square test on the proportion of respondents who indicate that information on medication is provided by doctors, specialists and pharmacists.

Question 37 addresses the hypothesis that private patients initiate actions to redress problems encountered with medical products and services. The chi-square test would be employed to gauge whether or not consumers are responsible enough to initiate actions for redress.

Questions 38-40 pertain to the responses that consumers receive after complaining, and what the form of redress should be in their opinion. These questions would enable the implementation of a chi-square test which would determine whether the hypothesis, that patients have an adequate system of redress for unsatisfactory products and services, should be accepted or rejected.

The hypothesis addressed in question 41, that patients would not prefer medicines to be accompanied by samples to test for allergic reactions, would be decided upon the implementation of the binomial large sample sign test. This question also addresses the right to safety (of medical products) and the provision of a method to test for the possible danger rather than the efficacy of the product.

Question 42 embraces a controversial issue among members in the medical fraternity:- whether doctors should advertise or not. The response to this question may indicate how consumers feel in this regard. Opportunity is provided in questions 42 and 43 for an explanation for their choice and for an identification of aspects that they would like to be informed about.

Service quality performance aspects, are addressed in questions 44-52. The basic aspects of appointments for consultation, the time spent waiting to be attended by family doctors and specialists and the sentiments of patients who have to wait are dealt with in questions 44-48.

The difference in duration of the waiting period between family doctors and specialists would be subjected to a Chi-square test.

The ease or difficulty of making appointments with specialists is addressed in question 49.

Telephonic accessibility in cases of misunderstandings, allergic reactions and results of tests, are addressed in questions 50-51. The patients opinions on inaccessibility via the telephone are addressed in question 52. The hypothesis that doctors are accessible for urgent attention via the telephone would be subjected to a large sample sign test to determine the acceptance or rejection of the hypothesis.

Overservicing, which has been cited as a bone of contention in the private medical sector viz. proponents of a national health service in Chapter 5, is addressed in question 53.

Questions 54-58 embrace personal details, which are necessary to facilitate cross tabulations between a variety of aspects such as the level of education, or race, or income and the various other aspects covered in the questionnaire.

Income may also be correlated with the patronage of private medical services in question 1 and may be subjected to a chi-square test to evaluate the null hypothesis that higher income groups do not make use of private medical care facilities.

9.9. PILOT SURVEY

The preliminary questionnaire was randomly distributed to 20 respondents (household heads and/or spouses) to ascertain the suitability of the questionnaire, and to elicit additional responses to the prestructured questions. The answers to the prestructured questions were intended to serve as probes as well as to assist in recall. In addition, it facilitated preparation for recording and coding. Respondents were also asked to indicate any semantic difficulties that they encountered whilst completing the questionnaire. This pilot study was concluded during April 1991. Seventeen completed questionnaires were collected. Although none of the participants indicated an unwillingness to participate in the pilot study, 3 respondents did not complete their questionnaires on or before the stipulated date of return. Indeed, many respondents expressed an interest in the nature of this investigation.

After the perusal of the completed preliminary questionnaires, a decision was made to insert new response options to some

categories, and to include two more pertinent questions. Apart from these amendments, the questionnaire remained unaltered. A copy of the final questionnaire is included as Appendix G.

9.10. FIRST PHASE OF THE SURVEY

The survey commenced during the first week in May 1991, when research assistants participated in the distribution of 170 questionnaires to respondents within the Durban Magisterial District, who had been randomly selected by the researcher.

In a number of cases assistants reported that respondents had expressed reservations about completing the questionnaires, because they were afraid that victimization could result. However, upon being reassured that the questionnaire was anonymous and that the names of medical practitioners were not required, they then participated willingly.

The survey was concluded during the last week in May when 137

completed questionnaires were collected. This indicated a response rate of 80.59%, $(\frac{137}{170} \times \frac{100}{1})$ which was considered to be adequate for the envisaged statistical tests.

9.11. THE SECOND PHASE OF THE SURVEY

The second phase of the survey involved data collection from providers and facilitators of medical products and services, with the aim of elucidating on certain pertinent aspects of the health care system. This exercise also provided an opportunity to compare the views of the providers and facilitators on some common variables that were researched in the first phase of the study.

The most striking feature of this phase was the great difficulty experienced in obtaining interviews with the medical practitioners. Some medical practitioners were understandably busy and their receptionists indicated that they "were unlikely to grant an interview, since they did not even have the opportunity to return their patients' calls." In view of the difficulty experienced in gaining access to the doctors at

their offices, attempts were made to telephone them at their homes to request either a telephonic or personal interview that lasted less than 5 minutes. Of the 25 specialists and general practitioners that were asked to participate in the survey, 8 specialists and 3 general practitioners refused to participate in the survey. Of the 14 that consented, some were very cautious about their responses, while the others were very helpful.

Representatives of medical associations and other related associations were also extremely cautious during the interviews.

Administrators of the 6 private hospitals and clinics in the study area, also provided information with some reservations.

Pharmaceutical manufacturing companies represented the lowest response rate with only 6 responses out of 15. Some companies requested a written commitment that the information provided by them would be treated confidentially.

Administrative associations of medical aid schemes were very responsive and expressed interest in the nature of this study.

The information obtained during this subsidiary phase would also be incorporated in the interpretation of the results of the first phase of the study. However, this data will not be subjected to statistical tests, but the information is expected to provide meaningful insights with regard to some critical issues embraced in the first phase of this study as well.

9.12. SUMMARY

The rationale of the study namely, to determine the perceptions of private patients with regard to private medical care was recalled with a view to appropriately designing the research methodology.

The Durban Magisterial District was selected, since it is believed to have a high density of private medical consumers as well as private practitioners. However, by confining attention to the Durban Magisterial District, the perceptions of the rural populations would be excluded. It is acknowledged that the perceptions of these patients could affect the

general validity of these results in view of the greater problems of accessibility, ability to pay, lower levels of education, and a greater reliance on alternative forms of treatment.

The survey method selected for the first phase of the study was the personal distribution and collection method. This was found to be the most appropriate since it enjoys a combination of advantages of the other methods that were analysed.

All other available methods were used for phase two of the study in an attempt to secure the co-operation of the professionals in the medical sector.

The random sampling method was selected for phase one and for parts of phase two. Many respondents in phase two were deliberately sought because of their positions within the relevant organisations.

A sample of 170 respondents was decided upon in phase one in order to facilitate the statistical computation of various hypotheses. A sample of 50 was selected for the second phase of the study.

Non-parametric statistical techniques to be applied in testing the validity of the hypotheses were explained, together with the motivation for the questionnaire.

Given the limitations in a study of this nature, it is nevertheless expected that the results would contribute to an understanding of the factors that impact on patient disconfirmation. The results of this study will be analysed and interpreted in the next chapter.

CHAPTER 10

ANALYSIS AND INTERPRETATION

10.1. INTRODUCTION

The first step, upon receipt of the questionnaires, was to develop a basic data array. A basic data array is a table comprising the value of each variable for each sample unit.

Each completed questionnaire was examined by the researcher in order to obviate inconsistencies, before it was entered into the computer.

Some questionnaires were returned with some questions unanswered, because those variables were not applicable to those respondents.

One way frequency distributions or simple tabulations were generated by the computer. These nominal data were employed to test some of the hypotheses.

Cross tabulations were also generated by the computer. These were used in the construction of tables to see how respondents with a given value on one variable responded to one or more other variables. Some of these were also used to test other hypotheses.

Since the central null hypothesis is a function of the subsidiary hypotheses, it would only be possible to determine its acceptance or rejection upon an analysis of the others. Consequently, it will be the final hypothesis to be tested.

Although information on the socio-economic status of the respondents was gathered in the last section of the questionnaire, it is nevertheless presented and analysed first in order to facilitate useful comparisons and correlations with other pertinent variables.

10.2. SOCIO-ECONOMIC PROFILE OF RESPONDENTS

Socio-economic attributes were collected in order to present a profile of the private patient.

The attributes that were considered to be pertinent to this study were education, income level, age of household head/spouse, household size and the race of respondents as well as their doctors.

10.2.1. Educational level

When the educational level of respondents and spouses were examined, at least 167 (75.57%) were matriculated, while 83 (49.7%) of these had post matric qualifications, and 27 (12.21%) were post matric students. It may therefore be inferred from this that the average household head and spouse had a fairly high level of education which could enable them to make intelligent assessments of their medical needs and the circumstances surrounding the fulfilment of those needs.

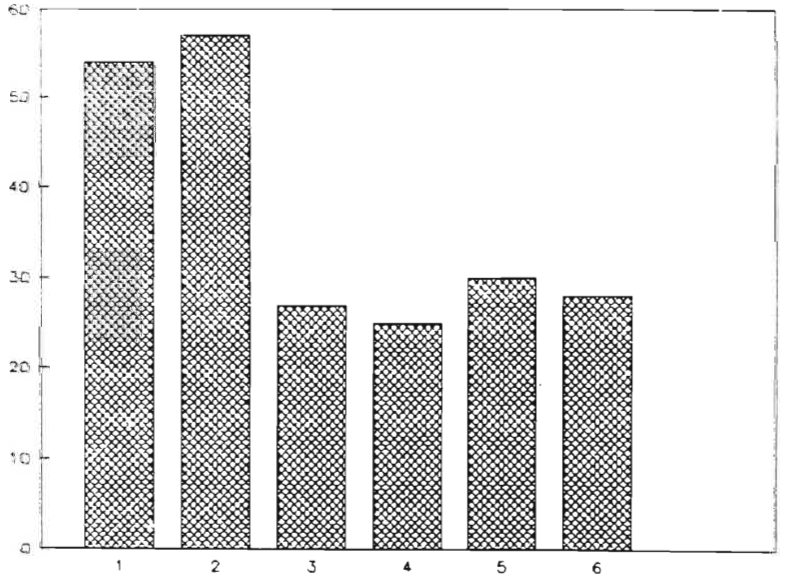
Moreover, education has often been positively related to an increasing awareness of a person's rights and a desire to know more about what affects the quality of his/her life. Consequently assessments of service quality can be made more meaningfully.

TABLE 10.1: EDUCATIONAL LEVEL OF RESPONDENTS AND SPOUSES

	RESPONDENTS		CUMULATIVE FREQUENCY	
	NO.	%	NO.	%
1. Less than matric	54	24.43	54	24.43
2. Matric	57	25.79	111	50.22
3. Post matric student	27	12.17	138	62.39
4. Graduate	25	11.31	163	73.7
5. Post matric diploma	30	13.57	193	87.27
6. Post graduate	28	12.67	221	100
TOTAL	221			

The level of education of the respondents and their spouses is depicted in the bar chart below.

FIGURE 10.1: EDUCATIONAL LEVEL OF RESPONDENTS AND SPOUSES



10.2.2. Race

Although the issue of indicating one's race has raised much controversy recently, it was found that all the respondents provided this information without any reservation. Although it may be seen that the majority of respondents were Whites and Indians, the majority of those who did not return the questionnaires were Coloureds and Blacks. Although researchers attempted to collect the completed questionnaires on three further visits, they did not succeed. The respondents had not completed the questionnaires and appeared to have no inclination to do so.

Tables 10.2. and 10.3. indicate the extent to which inter-racial patronage of medical professionals exist.

TABLE 10.2: INTER-RACIAL PATRONAGE OF GENERAL PRACTITIONERS

RESPONDENT'S	GENERAL PRACTITIONER'S RACE				
RACE	WHITE	BLACK	INDIAN	COLOURED	TOTAL
WHITE	35	2	2	1	40
BLACK	0	2	3	1	6
INDIAN	2	0	76	0	78
COLOURED	2	0	6	5	13
TOTAL	39	4	87	7	137

The majority of respondents tend to patronize general practitioners who belong to the same racial groups as themselves. However there appears to be a greater degree of inter-racial patronage of specialists.

TABLE 10.3: INTER-RACIAL PATRONAGE OF SPECIALIST

	SPECIALIST'S RACE				
RESPONDENTS RACE	WHITE	BLACK	INDIAN	COLOURED	TOTAL
WHITE	29	0	3	0	32
BLACK	3	1	0	0	4
INDIAN	10	0	58	0	68
COLOURED	0	0	6	1	7
TOTAL	42	1	67	1	111

10.2.3. Household Income

Total household income per month indicated that 16 [11.68%] received a low income (less than R1 500), 76 [55.47] were in the middle income group [R1 500 - R4 500] while 45 [32.85%] were in the higher income group [4 500 - 7 500 and more than 7 500].

10.2.4. Age of respondents

The ages of the household heads and spouses is presented in Table 10.4.

TABLE 10.4: AGE OF RESPONDENTS AND SPOUSES

	AGE			
	UNDER 30	30 - 45	45 - 60	OVER 60
RESPONDENTS	16	58	44	15
SPOUSES	17	55	3	3

10.2.5. Household Size

Household size is presented in Table 10.2.5.

TABLE 10.5: HOUSEHOLD SIZE

	HOUSEHOLD SIZE			
	0 - 2	2 - 6	6 - 10	MORE THAN 10
NO. OF RESPONDENTS	21	97	16	3

Having presented a socio-economic profile of the respondents, in the Durban-Magisterial District, it is now pertinent to examine their perceptions of the system of health care delivery that is available to them before an analysis is made of the satisfaction that they derive from the system. Patients have a choice between a privatized health care service, a state-subsidized health service or a combination of both. Their choice of either system depends on various factors which will also be examined in this study.

10.3. SYSTEM OF HEALTH CARE DELIVERY

H1 The majority of residents in the Durban Magisterial District do not receive private medical care.

Alternate: The majority of residents in the Durban Magisterial District receive private medical care.

The majority of the respondents i.e. 93 (67.9%) received medical treatment from private practitioners only, while only 4 (2.9%) received medical treatment from government subsidized facilities only. Forty (29.2%) received treatment from both private and government subsidized facilities, but of those 30

(22%) used the services of private practitioners to a greater extent than government subsidized facilities. Effectively the private sector patronage by respondents increases to 123 (89.78%).

The binomial large sample sign test was implemented to determine private sector patronage among the respondents. It produced a value of 9.316 which is larger than the critical value of 1.645 at the 0.05 level of significance. Accordingly the null hypothesis must be rejected in favour of the alternative which states that the majority of households in the Durban Magisterial District receive private medical care.

When preferences for systems of delivery in general were probed, 99 [72.3%] respondents preferred the establishment of a National Health Service in the Republic of South Africa. 62 [62.63%] of these respondents patronize private practitioners only. 30 respondents [21.89%] still prefer the existing system of health care delivery. However in the absence of a National Health Service, 107 respondents [78.1%] prefer private medical treatment while 30 [21.89%] prefer treatment from government subsidized facilities.

H2 Medical consumers are opposed to the establishment of a National Health Service.

Alternate: Consumers would prefer the establishment of a National Health Service.

When the preference for a National Health Service was subjected to the binomial large sample sign test, a value of 5.212 was obtained. Since this value is greater than 1.645 at the 0,05 level of significance the null hypothesis must be

rejected, in favour of the alternative, which states that medical consumers prefer the establishment of a National Health Service in South Africa. A chi-square test was implemented to determine whether there was a significant difference among the various income groups with regard to their preference for either National Health Service or the existing system of delivery.

TABLE 10.6. PREFERENCE FOR SYSTEM OF DELIVERY AMONG VARIOUS INCOME GROUPS

INCOME GROUPS	PREFERENCE FOR SYSTEM OF DELIVERY		
	EXISTING SYSTEM	NHS	TOTAL
Low Income	4	12	16
Middle Income	15	56	71
Higher Income	11	31	42
TOTAL	30	99	129

An observed x^2 value of 0,46 was obtained which is less than 5.99; d.f = 2 $p < 0,05$. Consequently there appears to be no significant difference in the preference for the system of delivery among various income groups. The degree of relationship between income groups and preference for the system of delivery based on the contingency coefficient test is 0,04.

TABLE 10.7. PREFERENCE FOR NATIONAL HEALTH SERVICE BY EDUCATIONAL LEVELS OF RESPONDENTS AND SPOUSES

EDUCATIONAL LEVEL OF RESPONDENTS AND SPOUSES	PREFERENCE FOR NHS	
	YES	NO
Less than matric	44	2
Matric	37	5
Post matric student	20	1
Graduate	16	2
Post matric diploma	26	0
Post graduate	21	1
TOTAL	164	11

It is also clear that the educational level of respondents played no part in the overwhelming support for a NHS. Of the 25 participants in the second phase of the survey who commented on the National Health Service, 14 of them indicated that an NHS would best serve the majority of the population, especially the indigent and the aged. The others (11) were of the opinion that the NHS is not feasible in South Africa. Some private practitioners who had served within the British NHS believed that "the long waiting period for surgical procedures did not justify its establishment." A specialist consultant who is serving under the British NHS agreed that long waiting periods for surgical procedures is indeed a problem but steps are being implemented to reduce this. Despite some of the problems inherent in an NHS, he believed that it was nevertheless "a better option than the present system of private medical care in South Africa where the 'mercenary' aspect appears to be the predominant feature, much to the detriment of patients."

On the other hand the Health Policy Directorate of Masa, views the establishment of a national insurance system as a feasible alternative to cater for the funding of state health care responsibilities. The Directorate also believes that private insurance through restructured private medical schemes is also an "acceptable approach for the funding of private sector health care delivery."

H3 The use of private medical care is not related to medical aid membership.

Alternate: The use of private medical care is positively related to medical aid membership.

Preference for private medical treatment in the present circumstances seems to be related to medical aid membership, since 84 (61.3%) of respondents indicated that one of their reasons for private sector patronage is that they are members of medical aid schemes. The implementation of the binomial sign test produced a value of 2.65. Since the observed value is greater than the critical value of 1.645 at the 0.05 level of significance, the alternative hypothesis that the use of private medical care is related to medical aid membership, may be accepted.

Table 10.8 presents an ordinal ranking of the reasons for the use of private facilities:

TABLE 10.8: REASONS FOR USE OF PRIVATE MEDICAL CARE

	NO.	%	RANK
Because of Medical Aid Membership	84	61.3	1
Better treatment than at state subsidized facilities	55	40.1	2
Facilities are better	39	29.5	3
Personal preference even though total payment made personally	12	8.8	4
Available after working hours	8	5.8	5
Proximity to home	5	3.6	6
Waiting periods are not as long	4	2.9	7

As regards waiting time, out-patient hours of operation at state subsidized centres tends to limit access to employed people who are unable to take long breaks in order to be treated at these centres.

10.4. PATIENT SATISFACTION

The measurement of patient satisfaction is complicated by the fact that satisfaction depends on individual levels of aspiration or expectations as well as the individual's perception or evaluation of outcomes. Carman (1990:47) believes that

> "it is reasonable to expect that perceptions of quality are influenced by expectations."

In addition Carman (1990:33) asserts that

> "the conceptualization and measurement of service quality (upon which satisfaction is based) has been an elusive concept primarily because of service intangibility, the

problems associated with simultaneous production and receipt of a service and the difference between mechanistic and humanistic quality."

Rudd and Glanz (1989:254) submit that

"patient satisfaction is a concept that appears to be correlated with evaluation of the quality of care. Typically, favourable perceptions of quality are associated with greater satisfaction. When viewed within a framework of consumer information processing, patient satisfaction represents postpurchase evaluation, and thus becomes part of the cumulative consumer learning used for future decision rules and processes."

Private patients had to select one of 3 options with regard to the general degree of satisfaction they derived from their family doctors, specialists and private hospitals. This is reflected in Table 10.9.

TABLE 10.9: LEVELS OF SATISFACTION BY DIFFERENT CATEGORIES OF HEALTH CARE PROVIDERS

	NOT SATISFIED		FAIRLY SATISFIED		VERY SATISFIED		ROW TOTAL
	NO.	%	NO.	%	NO.	%	
FAMILY DOCTOR	8	5.8	57	41.6	61	44.5	126
SPECIALIST	6	4.4	46	33.6	47	34.3	99
PRIVATE HOSPITAL	11	8	48	35	31	22.6	90
COLUMN TOTAL	25		151		139		315

H4 Private medical consumers are satisfied with services provided by private practitioners.

Alternate: Private medical consumers are dissatisfied with services provided by private practitioners.

It was noticed that 7 of the respondents did not respond to this question. They could have been respondent's who patronised state subsidized facilities to a greater extent than private facilities and thus considered themselves "unqualified to comment". The observed x^2 value was 6.22 which is less than the critical value of 9.49; d.f = 4; $p < 0,05$. Consequently the hypothesis that consumers of private medical services are satisfied with the services provided by private practitioners, could not be rejected. However, upon a reflection of Table 10.11, it will become evident that many factors dissatisfied patients even though they were, in general, satisfied with private medical care. The degree of relationship between private health care providers and the level of satisfaction based on the contingency coefficient test was 0,347.

Despite the fact that 61 respondents (44.5%), 47 respondents (34.3%) and 31 respondents (22.6%) indicated that they were very satisfied with their family doctors, specialists and/or private hospitals respectively, there were nevertheless many aspects related to the delivery of medical care, with which they were dissatisfied. This appears to be consistent with Bitner's (1990:72) study, where she found that variations in physical environment and attitudes and behaviours of service participants, affect perceptions of an experience independently of the actual outcome.

TABLE 10.10: LEVELS OF SATISFACTION BY FACTORS CONTRIBUTING TO SATISFACTION

FACTORS CONTRIBUTING TO SATISFACTION	NOT SATISFIED			FAIRLY SATISFIED			VERY SATISFIED				
	GP	SP	HP	GP	SP	HP	GP	SP	HP	TOTAL	RANK
Kind and caring attitude of doctor	3	2	1	34	16	5	60	32	8	161	1
Kind and caring attitude of staff	3	0	2	21	10	9	50	23	10	118	3
Available after hours	3	0	2	18	8	7	44	11	9	102	6
Proper explanation of illness	1	1	0	22	17	1	44	26	5	117	4
Clean and pleasant waiting rooms	3	1	2	28	21	5	43	27	9	139	2
Answers telephone queries	2	1	1	22	10	2	44	22	5	109	5
Other	4						2	2		8	7
TOTAL	19	5	8	145	82	29	277	143	46	754	

GP = General Practitioner

SP = Specialist

HP = Hospital

PH = Pharmacist

The most important factor contributing to satisfaction among the various providers of private health care, was cited as the "kind and caring attitude" of doctor, specialist and hospital doctor. This is consistent with the findings of Swedish researchers Reader, Pratt, and Mudd (1957:90) and Gochman, Stukenborg and Feler (1986:23). Although there is a difference of about 30 years between these two studies, the conclusions were nevertheless the same. With regard to patients' concept of a good doctor, "kindness, understanding, interest, sympathy and encouragement" were the most desired attributes in a doctor.

Rudd and Glanz (1989:254) also noted "significant intercorrelations among the major dimensions of patient attitudes towards physician conduct, availability of services, continuity/convenience and access.

Fiedler (1981:138) also found that

> "Various characteristics and practices of providers contribute to patient satisfaction. Patients were more satisfied when providers:-
>
> * provided more information;
> * counselled patients;
> * explained payment plans;
> * had a favourable attitude toward the patient;
> * spent more time with the patient;
> * treated patients in pleasant rooms; and
> * attended to patients punctually.

Fiedler also believes that patient satisfaction is a powerful predictor of patient compliance, preventative care and of continued service encounters with the same doctor.

Table 10.11 reflects the correlation between the levels of satisfaction indicated by respondents and factors that contribute to some degree of dissatisfaction.

TABLE 10.11: LEVELS OF SATISFACTION BY FACTORS CONTRIBUTING TO DISSATISFACTION

FACTORS CONTRIBUTING TO DISSATISFACTION	RESPONDENTS										
	NOT SATISFIED			FAIRLY SATISFIED			VERY SATISFIED				
	GP	SP	HP	GP	SP	HP	GP	SP	HP	TOTAL	RANK
Long waiting period	4	4	4	20	11	11	17	10	7	88	2
Unpleasant staff	1	1	4	10	3	11	0	2	5	37	4
Wrong diagnosis	6	1	1	11	1	4	1	2	1	28	7
Overcharging	4	2	4	30	27	19	10	17	11	124	1
Ill mannered doctor	2	2	1	2	4	3	0	0	1	15	9
Treated with no respect	0	0	2	2	3	2	0	0	3	12	10
No assistance in emergencies or at night	6	3	1	30	15	2	13	9	4	83	3
Submits account for telephone consultation	0	0	1	4	3	1	0	0	2	11	11
Answer non urgent calls while attending to patient	2	0	0	12	4	0	6	1	0	25	8
Doctors hours of consultation too limited	2	1	0	12	6	2	5	3	0	31	5
Untidy, gloomy waiting rooms	3	0	2	14	1	5	4	0	1	30	6
TOTAL	30	14	20	147	78	60	56	44	35	484	

The table reflects that even though the majority of respondents might have indicated that they were either fairly satisfied or very satisfied with the services rendered by private practitioners or private hospitals, there were nevertheless, attendent circumstances which produced varying degrees of dissatisfaction. This is likely to impact negatively upon the total service encounter.

Respondents' perceptions that private medical providers were overcharging appeared to be the most striking factor that contributed to dissatisfaction since this was ranked first. Long waiting periods and the fact that respondents had difficulty in seeking assistance in emergencies also contributed towards a considerable degree of dissatisfaction among respondents, since these factors were ranked second and third respectively.

The following table reflects the correlation between consumers of different educational levels and the levels of satisfaction they experienced.

TABLE 10.12 : LEVEL OF SATISFACTION BY EDUCATIONAL LEVEL OF RESPONDENTS AND SPOUSES

EDUCATIONAL LEVEL OF RESPONDENTS AND SPOUSES	NOT SATISFIED				FAIRLY SATISFIED				VERY SATISFIED				
	GP	SP	HP	TOT	GP	SP	HP	TOT	GP	SP	HP	TOT	TOTAL
Less than matric	2	1	2	5	15	13	15	43	27	19	15	61	109
Matric	2	1	3	6	21	20	24	65	32	23	19	74	145
Post matric student	2	2	0	4	15	13	11	39	9	5	2	16	59
Graduate	1	0	3	4	14	10	5	29	10	10	6	26	59
Post matric diploma	3	6	4	13	14	8	16	38	12	10	3	25	76
Post graduate	2	0	6	8	13	12	11	36	10	9	5	24	68
TOTAL	12	10	18	40	92	76	82	250	100	76	50	226	516

TABLE 10.13 : PROPORTION OF RESPONDENTS AND SPOUSES OF VARIOUS EDUCATIONAL LEVELS WHO ARE NOT SATISFIED WITH SERVICES RENDERED BY PRIVATE PRACTITIONERS

EDUCATIONAL LEVEL OF RESPONDENTS AND SPOUSES	RESPONDENTS & SPOUSES NOT SATISFIED	
	PROPORTION	PERCENTAGE
Less than matric	$^{5}/_{109}$	4.5
Matric	$^{6}/_{145}$	4.1
Post matric student	$^{4}/_{59}$	6.78
Graduate	$^{4}/_{59}$	6.78
Post matric diploma	$^{13}/_{76}$	17.10
Post graduate	$^{8}/_{68}$	11.76

A chi-square value was computed on the totals obtained from the 3 levels of satisfaction. A value of 34.78 was obtained which is higher than the critical value of 18.3 d.f = 10; $p < 0,05$. Evidently there was a significant difference in the perception of satisfaction by consumers of different educational levels. It might be observed that the higher the level of education, the greater the expectation of respondents and spouses in the higher educational levels indicated that they were dissatisfied. These proportions are also indicated in Table 10.13. An interesting point to observe is that, although 19 (14.28%), 5 (3.75%) and 8 (6%) respondents indicated that they were dissatisfied with the services of general practitioners, specialists and hospitals respectively, 53 (39.8%) of the respondents indicated that they experienced dissatisfactions with their general practitioners and 21 (21.2%) of the 99 respondents who consulted specialists experienced dissatisfaction as addressed in question 24. It may be presumed that the responses to question 24 included all aspects of the delivery of services, that is the total marketing mix, rather than the actual performance of service by the practitioner.

10.5. USE OF STATE SUBSIDIZED FACILITIES

Although the focus of this study is on private patients, these questions were posed because some patients use both forms of health care. The questions regarding state subsidized facilities were intended to probe the reasons for its patronage; and the factors that contributed to satisfaction or dissatisfaction, with a view to serving as a form of comparison with private facilities.

These results are reflected in Table 10.14, 10.15 ad 10.16. The number of respondents in Table 10.15 exceeded 44 (which was the number actually using only state subsidized facilities), since some private patients who had used State facilities previously also provided responses to these questions.

Table 10.14 depicts the reasons given by respondents for the use of State facilities.

TABLE 10.14: REASONS FOR USE OF STATE FACILITIES

	RESPONDENTS		
REASONS	NUMBER	PERCENTAGE	RANK
Not enough money to pay for private medical care	21	15.3	1
Better equipment	15	10.9	2
Not a member of medical aid scheme	13	9.5	3
Other	8	5.8	4
Total	57	41.5	

The inability of patients to pay for private medical care is the major reason for the use of State subsidized facilities. The perception by 15 respondents that State subsidized facilities have better equipment may be attributed to the fact that all diagnostic procedures and equipment are in a central location as opposed to private facilities where patients must go from one doctor to another to yet another, each in a different location. However, it is not being suggested that state

subsidized centres do not have better equipment. Only a thorough assessment of the facilities in both state subsidized centres and private practices could confirm this.

Factors that contribute to dissatisfaction and satisfaction are indicated in Tables 10.15 and 10.16 respectively.

TABLE 10.15: FACTORS CONTRIBUTING TO DISSATISFACTION AT STATE SUBSIDISED CENTRES

FACTORS CONTRIBUTING TO DISSATISFACTION	RESPONDENTS		
	NUMBER	PERCENTAGE	RANK
Long waiting periods	53	38.7	1
Untidy, unpleasant waiting rooms	42	30.7	2
Lack of respect/compassion of staff	37	27	3
Lack of sufficient treatment facilities	36	26.3	4
Lack of respect/compassion of doctors	22	16.1	5
Other	5	3.6	6

TABLE 10.16.: FACTORS CONTRIBUTING TO SATISFACTION AT STATE SUBSIDISED CENTRES

FACTORS CONTRIBUTING TO SATISFACTION	RESPONDENTS		
	NUMBER	PERCENTAGE	RANK
Low cost of treatment	40	29.2	1
Greater value for money	24	17.5	2
Caring doctors	19	13.9	3
Caring staff	12	8.8	4
Easily accessible at all times	12	8.8	4

Although these findings may be viewed with some reservation because of the smaller number of respondents patronizing State facilities, in this study, they are nevertheless consistent with the results obtained by Thomson and Myrdal (1985 : 59) in their South African study of the reasons for patients' use of State subsidized primary health care centres. The major factor contributing to satisfaction in their study was also the "lower cost of treatment" and the major reason for dissatisfaction was the "long waiting period."

10.6. USE OF STATE SUBSIDIZED FACILITIES BY PRIVATE PATIENTS

H5 **Private medical consumers would avoid state facilities even if there were an improvement in the methods of delivery of public medical care.**

Alternate: Private medical consumers would utilize state facilities if there were an improvement in the methods of delivery of state subsidized medical care.

Of the 123 "private patient" respondents, 82 indicated that they would use state subsidized facilities if conditions improved substantially. The binomial sample sign test revealed a critical value of 1.645 for a one tailed test at the 0,05 level of significance. Since the observed statistic of 3.73 is larger than the critical value, the alternative hypothesis that private consumers would utilize public facilities if there is an improvement in the method of delivery of public medical care, must be accepted. Table 10.17. reflects the responses of various income groups in this regard.

TABLE 10.17: ENVISAGED USE OF STATE SUBSIDIZED FACILITIES BY PRIVATE PATIENTS WITH VARYING INCOME LEVELS

INCOME LEVELS	ENVISAGED USE OF STATE SUBSIDIZED FACILITIES		
	YES	NO	TOTAL
Low Income	8	8	16
Middle Income	49	27	76
Higher Income	25	20	45
TOTAL	82	55	137

When the responses of respondents of various income groups were considered an observed chi-square value of 1.67 was obtained which is less than 5.99; d.f = 2; $p < 0,05$. Consequently there is no significant difference among the responses of the various income groups as regards the envisaged use of state subsidized facilities. The degree of relationship between these variables based on the contingency coefficient test was 0,142.

10.7. PERCEPTION OF PRIVATE PRACTITIONERS' ROLE IN THE HEALTH CARE SYSTEM

H6 Medical consumers believe that the main purpose of private practitioners is profit maximization.

Alternate: Medical consumers do not believe that the main purpose of private practitioners is profit maximization.

It has often been alleged by critics of privatization that private practitioners assume an entrepreneurial role and consequently consider profit to be their main objective. The following table reflects private patients' perceptions of private practitioners' objectives in the health care system.

TABLE 10.18: RESPONDENT'S PERCEPTIONS OF MEDICAL PRACTITIONERS' OBJECTIVES IN THE PRIVATE SECTOR

OBJECTIVES	MEDICAL PRACTITIONER					
	GP RESPONDENTS		RANK	SP RESPONDENTS		RANK
	NO.	%		NO.	%	
To assist the population with their health problems	57	41.6	2	27	19.7	3
To offer better services than state institutions	52	38	3	37	27	2
To make as much money as possible	67	48.9	1	50	36.5	1
Other	5	3.6	4	1	7	4

The totals in each column exceed 133 and 99 respectively since respondents provided more than one answer in each category. It appears that the private patients in this study also tended to

consider the primary objective of private practitioners to be profit maximization, since this was ranked first. Moreover, the null hypothesis that medical consumers believe that the main purpose of private practitioners is profit maximization cannot be rejected, since the observed value upon the implementation of the chi-square test is 2.43 which is less than 5.99; d.f = 2; $p < 0,05$. Although a significant proportion of respondents (48.9%) tended to consider the primary objective of private practitioners to be profit maximization, another significant proportion (41.6%) also perceived the private practitioners' objective to be, to assist the population with their health care needs.

10.8 FACILITATIVE ORGANISATIONS

10.8.1. Medical Aid Schemes

H7 Medical aid members believe that medical aid membership is not necessary in order to receive private medical care.

Alternate: Medical aid members believe that medical aid membership is necessary in order to receive private medical care.

Membership of medical aid schemes has been cited as an important reason for patronage of private medical services. 96 respondents (72.18%) are members of medical aid schemes. Use of the large sample sign test yielded a value of 4.7 which is larger than the critical value of 1.645 at the 0,05 level of significance. Thus the alternative hypothesis that patients who use the services of private practitioners are usually members of medical aid schemes may be accepted. The recent emergence and the increasing use of the medical insurance policies

does not appear to have made its impact as yet, as an alternative means of accessing private medical care. Medical insurance policies were held by 24 respondents (17.5%).

The number of respondents who actually desired to be members of medical aid schemes was 66 (48.2%).

TABLE 10.19: PREFERENCE FOR MEMBERSHIP OF MEDICAL AID SCHEMES BY INCOME GROUPS

INCOME GROUP	PREFERENCE FOR MEDICAL AID MEMBERSHIP		
	YES	NO	TOTAL
Low income	7	3	10
Middle income	34	20	54
Higher income	25	7	32
TOTAL	66	29	96

The observed x^2 value was 1.37 which is less than the critical value of 5.99; d.f = 2; $p < 0,05$. This implies that there is no significant difference between the various income groups with regard to preference for medical aid membership. The degree of relationship between these variables is 0,138.

According to Table 10.20. it appears that the size of the household also does not impact significantly on preference for medical aid membership. The observed x^2 value was 2.2 which was less than the critical value of 5.99 d.f = 2; $p < 0,05$. The degree of relationship between household size and preference for membership was 0,222.

TABLE 10.20: PREFERENCE FOR MEDICAL AID MEMBERSHIP BY HOUSEHOLD SIZE

HOUSEHOLD SIZE	PREFERENCE FOR MEDICAL AID MEMBERSHIP		
	YES	NO	TOTAL
0-2 members	9	6	15
2-6 members	50	18	68
More than 6 members	7	6	13
TOTAL	66	29	96

However, only 52 (54.17%) of the existing 96 medical aid members actually preferred to be members of medical aid schemes and 13 respondents who were members of medical aid schemes also held medical insurance policies.

In many instances employees do not have an option of medical aid membership. They are compelled to become members upon employment, irrespective of their desire or need for it. The young and healthy might therefore consider their monthly contributions to be far in excess of needs and resent having to subsidize the sick and the elderly. The Registrar of Medical Schemes [Annual Report 1991:03:22] submits that this manner of spreading the risk of health care is one of the major principles on which medical schemes function. He adds that if a trend of resistance manifests itself in the system, other ways and means of subsidizing the elderly would have to be found.

H8 Medical aid members do not believe that medical aid schemes are being abused by members.

Alternate: Medical aid members believe that medical aid schemes are being abused by members.

Abuse of medical aid benefits perhaps, stemming from the member's perception of "his unfairly high contribution in lieu of benefits derived," has become increasingly evident. Table 10.21 reflects a high degree of awareness of abuse by medical aid members: 71 [73.96%] indicated that they were aware of abuse by members and 87 (90.63%) were aware of abuse by doctors. (The sample size was taken as 96 since only medical aid members had to answer these questions). Ninety five percent of the participants in the second phase of the survey who were asked about medical aid abuse, indicated that they were aware of abuse, not only by members, but by medical practitioners and pharmacists as well.

TABLE 10.21: MEDICAL AID MEMBERS' RESPONSES WITH REGARD TO MEDICAL AID SCHEMES

MEDICAL AID SCHEMES	MEDICAL AID MEMBERS RESPONDENTS				
	YES	%	NO	%	TOTAL
Are necessary in order to receive private medical care	71	73.96	25	26.04	96
Result in higher costs of medical care	85	88.54	11	11.46	96
Are being abused by members	71	73.96	25	26.04	96
Are being abused by doctors	87	90.63	9	9.38	96
Provide adequate financial cover	31	32.29	65	67.7	96
Act as representative organizations with regard to medical problems	22	22.92	74	77.08	96

The binomial sign test implemented to test the null hypothesis that medical aid schemes are not being abused by members resulted in an observed value of 4.69 which is greater than the critical figure of 1.645 at the 0,05 level of significance. Accordingly the alternate hypothesis, that medical aid schemes are being abused by their members can be accepted.

H9 Medical aid members do not believe that medical aid schemes are being abused by doctors.

Alternate: Medical aid members believe that medical aid schemes are being abused by doctors.

The binomial sign test was also implemented to test the null hypothesis that medical aid schemes are not being abused by doctors. The observed value of 7.96 was greater than the critical 1.645 at the 0.05 level of significance. Consequently the alternate hypothesis must again be accepted.

The types of abuse that were revealed by respondents include the following:-

* requests by members from doctors to prescribe greater quantities of medication than necessary, so that either the levy and the member's portion could be covered, or members could take other products from the pharmacist in lieu of the unnecessarily prescribed medication. Evidently a tacit collusion takes place among the three participants.

* members allow non-members to use their membership cards, in return for a fee.

* doctors charge for consultations that never take place, and the subsequent medical aid benefit is shared between the doctor and the member.

* Overservicing by some doctors such as unnecessary consultations; unnecessary procedures such as induced labour even in the case of normal pregnancies; unnecessary prescription of medication when medication can be avoided and unnecessary pathological tests, the results of which are never communicated to the patient.

H10 Medical aid members believe that medical aid schemes do not result in higher costs of medical care.

Alternate: Medical aid members believe that medical aid schemes result in higher costs of medical care.

The binomial large sample sign test was utilized to test members' perceptions as to whether or not the existence of medical aid schemes resulted in higher costs of medical care: 85 members believed that medical aid schemes resulted in higher costs of medical care. The observed value of 7.55 was larger than the critical value of 1.645. Thus the alternative hypothesis that medical aid schemes are perceived to result in higher costs of medical care was accepted. It would appear that the high degree of abuse discussed earlier is a contributory factor to this perception.

H11 Members of medical aid schemes would not visit their practitioners less often if they were not members of medical aid schemes.

Alternate: Members of medical aid schemes would visit their practitioners less often if they were not members of medical aid schemes.

The suggestion that members of medical aid schemes consult doctors for trivial medical problems, which can easily be self-treated, was probed by question 13. Fifty of the 96 respondents who were members of medical aid schemes indicated that they would continue to consult their doctors in similar circumstances as in the past, even if they were no longer members.

Application of the binomial large sample sign test to this response pattern produced a value of 0,408 which is less than the critical value of 1.645 for a one tailed test at the 0,05 level of significance. The null hypothesis could thus not be rejected (medical aid members would not visit their practitioners less often if they were not members of medical aid schemes). Although this finding appears to contradict the findings provided by Ross (1988:23) and the Registrar of Medical Aid Schemes, [Annual Report 1991: 3:22] that third party payment results in unnecessary use of private health care, it must be accepted with some reservation, since 16 respondents (16.66%) were uncertain of how they would react if they were faced with such a situation.

H12 Medical aid schemes do not provide inadequate financial cover for the needs of their members.

Alternate: Medical aid schemes provide inadequate financial cover for the needs of their members.

The perceived adequacy of financial cover was subjected to a binomial large sample sign test: 75 of the 96 members felt that the financial cover was inadequate.

The observed value was 3.47. Since this is greater than the required 1.645 at the 0,05 level of significance, the alternative hypothesis may be accepted.

H13 Medical aid members regard medical aid schemes as their representative organisations.

Alternate: Medical aid members do not regard medical aid schemes as their representative organisations.

The perceptions of respondents seems to differ from those of medical scheme administrators and Representative Associations of Medical Schemes.

Seventy four respondents who were members thought that medical aid schemes did not act as their representative organisations with regard to medical problems. As the observed value of 5.31 was greater than the critical value of 1.645, at the 0,05 level of significance, the null hypothesis that medical aid members do not regard medical aid schemes as their representative organizations, could be rejected in favour of the alternative.

Medical scheme administrators and the Representative Associations of Medical Schemes claim that they are vociferous representatives in trying to prevent escalating medical fees,inter alia by establishing a Scale of Benefits which doctors must adhere to. However, many doctors have "contracted out". In such cases members must pay the full, and much higher MASA amount charged, directly to the doctor and then claim for a refund which is based on the lower Scale of Benefits established by the medical aid schemes. Effectively, patients bear the cost of amounts charged in excess of the Scale of Benefits in addition to their obligatory proportion in terms of the relevant medical scheme benefits structure. Members whose doctors are "contracted-in" with medical schemes, are at an advantage since the Scale of Benefits Fees are lower than the Masa tariffs.

10.8.2. The Establishment of a Patients' Association

H14 Medical consumers would not support the establishment of a Patients' Association.

Alternate: Medical consumers would support the establishment of a Patients' Association.

Patients in South Africa do not have a voluntary representative association which promotes and protects the interests of patient's generally. Patients cannot present their views to a body which is independent of the government, health professions or the drug industry. Moreover they are unable to jointly promote understanding and goodwill between themselves and members of the medical profession. The medical profession on the other hand has a formidable group of associations whose aims are to promote and protect their interests.

The only association that is intended to serve the interests of the patients is the South African Medical and Dental Council. It is a regulatory body, made up primarily of members of the medical profession. It has been suggested that the role of the Council is not convincing to the majority of the patients and this appears to be verified by the responses to question 28b. Only 19.7% of the respondents indicated that they consider the SAMDC to be an adequate protector of their interests. One hundred and four respondents indicated that they preferred the establishment of a patients' association; 12 did not prefer one, while another 12 were uncertain. The null hypothesis, that the majority of patients are opposed to the establishment of patients' association was subjected to a large sample sign test. An observed statistic of 6.5 which is

larger than the critical value of 1.645 for a one tailed test at the 0,05 level of significance was obtained. Accordingly the alternative hypothesis may be accepted.

When a chi-square test was applied to determine whether there was a significant difference among the different income groups for the establishment of a Patient's Association, a value of 6.64 was obtained. Since the observed value is greater than the critical value of 5.99; d.f. = 2; $p < 0.05$, it is evident that there is a difference in desire among the different income levels for the establishment of a patient's association. The degree of relationship between these variables based on the contingency coefficient was 0,554.

Table 10.22. reflects the wishes of respondents of various income groups with regard to the establishment of a patients' association.

TABLE 10.22.: PREFERENCE FOR THE ESTABLISHMENT OF A PATIENTS' ASSOCIATION BY RESPONDENTS OF VARIOUS INCOME GROUPS

INCOME LEVEL	ESTABLISHMENT OF PATIENT'S ASSOCIATION		
	YES	NO/UNCERTAIN	TOTAL
Low	8	7	15
Middle	63	13	76
Higher	33	13	46
TOTAL	104	33	137

Among the 25 providers and facilitators of medical services and products with whom the issue of a patients' association was raised (i.e. participants in the second phase of the

survey), 17 (68%) believed that the establishment of an independent patients' association is desirable if it is staffed with people who have expert knowledge in the related fields, and who would be able to exercise judgement impartially. The other 8 participants (32%) felt that such an association is unnecessary where professionals conduct themselves ethically and in the interests of the patients. The latter is clearly a Utopian ideal which does not exist in South Africa.

10.9. COST OF PRIVATE HEALTH CARE

H15 Medical consumers do not consider the cost of private medical care to be excessive.

Alternate: Medical consumers consider the cost of private medical care to be excessive.

Health care costs are a function of the various services and products purchased, and the price of these services and products. Medical care costs have consistently outpaced price increases for many categories of consumer goods and services. Indeed 97 respondents (72.9%) considered the cost of private medical care to be excessive.

Apropos medical services, practitioners have attributed the increasing costs to the high costs of sophisticated diagnostic equipment which is claimed to produce more accurate diagnoses, upon which effective treatment can be based. Medical practitioners have also claimed that the costs of administering their practices have also increased substantially making fee increases imperative (Sunday Times 19/5/91:3). On the other hand, the majority (78.52%) of respondents (in the second phase of study), felt that overservicing of medical aid

patients contributed to the cost spiral for patients. It has been found in the USA that doctors who are owners or shareholders of medical equipment companies and clinics, such as T² Medical, are only prescribing products of that company. The prices of products of such companies are perceived by patients to be more costly than products of other companies. Indeed the earnings of that company rose by 75% in the third quarter [CNN : Health Week : 26.7.91]. Critics have stated that such practices were so unethical, that they ought to be outlawed. Such a study has not been conducted in the RSA as yet, even though the majority of shareholders in private hospitals and clinics in the Durban Magisterial District are medical practitioners (information derived from interviews of hospital administrators during second phase of study).

With regard to medication however, a National Productivity Institute survey of the pharmaceutical industry revealed that

> "inadequate productivity was the most important reason for escalating costs. Because of the amount of capital invested in machinery, capital productivity is a very important productivity determinant in the industry and it was found that the State Tender system had a negative impact on the industry's capital productivity since it impairs the industry's ability to set production goals or delivery times. Fifty percent of the sample companies agreed that tender prices were subsidised by prices in the private market while 17% disagreed " [SAPJ Nov 1989 : 383].

The survey, conducted in 1988, revealed a recorded decrease in production volumes of 5.4% from 1984-1988 which was not accompanied by a decrease in employment. The NPI observed that al-

though labour represented only 4.6% of manufacturing costs, labour productivity could easily be improved on average by 31.5%.

Another factor that contributes to the high cost of medicines is that 80% of raw materials have to be imported from overseas associate companies at high cost. Unfavourable exchange rates aggravate the situation when industries are dependent on imports.

Another factor that would contribute to the high cost of private medical care is the recent imposition of value added tax (VAT) on medical services and products.

However, it was reported that "medicine prices could drop by as much as 36% if medical aid schemes had the right to run pharmacies. This emerged from figures supplied by Transmed which is one of a few schemes that is allowed to run pharmacies" (Sunday Times Business; 15/9/91 : 1). Transmed revealed that "the average cost of an ethical medicine dispensed to its members by retail pharmacies was R43,80 compared to R27,80 for the identical one provided by Transmed's pharmacies". It was stressed that "the figure of R27,80 included overheads and was thus directly comparable." (Sunday Times Business; 15/9/91 : 1).

Requests have been made by medical aid administrators to amend the Pharmacy Act so that all schemes may be allowed to operate pharmacies. However present legislation prohibits this. This issue is bound to result in much controversy since pharmacists would consider this as a dismantling of the free enterprise system in the pharmaceutical industry.

When the perception of the cost of medical care was correlated with the household size, no significant difference was found to exist, since the observed x^2 value was 1,171. This was greater than the critical value of 5.99; d.f = 2, $p > 0,05$. The degree of relationship based on the contingency coefficient test was 0,101.

Consequently, it appears that the perception of the cost of medical care is not dependent on varying household sizes.

TABLE 10.23.: PERCEPTION OF COST OF MEDICAL CARE BY HOUSEHOLD SIZE

HOUSEHOLD SIZE	COST OF MEDICAL CARE		
	TOO HIGH	REASONABLE	TOTAL
0-2 members	18	4	22
2-6 members	76	19	95
More than 6 members	11	5	16
TOTAL	105	28	133

The hypothesis that consumers do not consider the cost of private medical care to be excessive was subjected to a binomial sign test resulting in an observed value of 4.871 (97 respondents believed that the cost of private medical care was excessive). Since the critical value of 1.645 at the 0,05 level of significance is less than the observed value, the alternative hypothesis that consumers consider the cost of private medical care to be excessive can be accepted.

Cash payments to private doctors by medical aid members who constitute the majority of the respondents in this survey, are not a common occurrence if the doctor is "contracted in". Therefore the figure of 15 (10.9%) attained in this question (Q.16b) on cash discounts by doctors to patients seems insignificant. Since 96 respondents were medical aid members, cash payments were unlikely except in the case of "contracted out doctors" and non medical aid members.

10.10. PRICING POLICY BY PRACTITIONERS

H16 Private medical consumers do not believe that doctor's fees should be based on a number of different factors.

Alternate: Private medical consumers believe that doctors fees should be based on various factors.

Pricing policy is an important factor in the exchange of products and services. It has become increasingly important in the private medical sector because of the increasingly higher costs of such services.

Consultations vary in terms of duration, diagnostic procedures, the nature of illnesses, and the equipment used. The null hypothesis that doctor's fees should not be based on a fixed fee per consultation was subjected to a chi-square test. The observed value of 18.56 was obtained. Since this was higher than the critical value of 5.99; d.f. = 2; $p \leq 0,05$, the alternative hypothesis, that doctors' fees should be based on various factors should be accepted. Moreover the degree of relationship between consultation fees and the factors to be considered, was high. The contingency coefficient value was 0,895.

Table 10.24 depicts the responses of private patients with regard to the factors that should be considered in determining the fees for consultation.

TABLE 10.24: FACTORS TO BE CONSIDERED IN DETERMINING CONSULTATION FEES

FACTORS	RESPONDENTS		
	YES	NO	TOTAL
Time spent with patients	89	48	137
Types of diagnostic equipment used	85	52	137
Nature of the treatment	115	22	137
TOTAL	289	122	411

The totals exceed 133 since more than one factor was cited by the respondents.

10.11. PATIENTS' RIGHTS AND RESPONSIBILITIES

10.11.1. Right to Information

H17 Private medical consumers do not have an informed choice with regard to private practitioners.

Alternate: Private medical consumers have an informed choice with regard to private practitioners.

The problem of acquisition of information about doctors is exacerbated by the fact that doctors are not allowed to advertise even with some ethical controls. The task of eliciting information seems to be formidable for patients who are "too respectful of professionals and are reticent to ask them or

their assistants, about their expertise, their training and education, and about their most recent success rates in their fields of specialization..." [Dr Levin M.D. : American dermatologist in a television programme Looking Good Part 7 viewed on TV1 on 15-7-91 at 14h00]

This lack of knowledge is not likely to contribute to a relationship of implicit trust in the doctors/specialist since more pertinent information leads to greater confidence in the doctor's capability.

Consumers in the USA, Britain, Canada, Sweden and Germany have in some instances organised to promote increased availability of information about health care services and to educate consumers in its use. (Rudd & Glantz 267)

TABLE 10.25: INFORMATION OBTAINED ABOUT PRIVATE PRACTITIONERS

	INFORMATION OBTAINED		
	NO	VERY LITTLE	YES, SUFFICIENT
DOCTOR	24	38	54
SPECIALIST	25	38	41

The null hypothesis that patients do not have an informed choice was subjected to a chi-square test which produced a value of 1.147 which is less than 5.99; d.f. = 2; $p < 0,05$. Thus the null hypothesis could not be rejected.

The majority of respondents 117 (85.4%) preferred to have information about their general practitioners while 109 (79.6%) indicated that they preferred to have information about the specialists before consulting with them.

The sources of information about general practitioners and specialists are indicated in Table 10.26.

TABLE 10.26: SOURCES OF INFORMATION ON PRIVATE PRACTITIONERS

SOURCES OF INFORMATION	PRIVATE PRACTITIONERS					
	GP			SP		
	NO.	%	RANK	NO.	%	RANK
Family doctor	23	16.8	4	52	38	1
Other doctors	32	23.4	3	15	10.9	4
Friends	76	55.5	1	37	27	2
Family	62	45.3	2	28	20.4	3
Other	3	2.2	5	2	1.5	5

The totals exceed the sample size since more than one source was cited by respondents. Friends appear to be the chief source of information for general practitioners, while general practitioners are the chief source of information for specialists. However, it must be pointed out that only 54 (39.42%) respondents considered that the information was sufficient, while 38 respondents (27.7%) considered the information insufficient to enable them to make an informed choice about their general practitioner. Only 41 respondents (29.9%) considered the information about their specialists to be sufficient.

TABLE 10.27: INFORMATION ABOUT DOCTOR/SPECIALIST BY VARIOUS INCOME GROUPS

	GENERAL PRACTITIONER			SPECIALIST		
	SUFFI-CIENT	VERY LITTLE	NO	SUFFI-CIENT	VERY LITTLE	NO
Low income	5	4	2	1	5	2
Middle income	26	26	13	23	20	17
Higher income	23	8	9	17	13	6
TOTAL	54	38	24	41	38	25

In addition, there appears to be no significant difference among the various income groups with regard to the degree of information obtained about specialists and doctors, since the observed x^2 value of 5,163 was obtained which is less than 9.49; d.f = 41 : $p < 0,05$.

When preference for information about practitioners was correlated by income levels of respondents, a chi-square value of 1.054 was obtained which is less than 5.99; d.f = 2; $p < 0,05$. Consequently, there appears to be no significant difference among the various income groups with regard to their preference for information about practitioners.

TABLE 10.28: PREFERENCE FOR INFORMATION ABOUT PRACTITIONERS BY INCOME GROUPS

	PREFERENCE FOR INFORMATION ABOUT		
	GP	SPECIALIST	TOTAL
Low income	12	7	16
Middle income	68	64	76
Higher income	37	38	45
TOTAL	117	109	137

Patients' preference for information about practitioners and the amount of information obtained before consulting with such practitioners is indicated in Table 10.29.

TABLE 10.29: DEGREE OF INFORMATION OBTAINED BY PREFERENCE FOR SUCH INFORMATION

PREFERENCE	INFORMATION OBTAINED			
FOR INFORMATION	SUFFICIENT	VERY LITTLE	NONE	TOTAL
G.P.	52	35	21	108
Specialist	40	35	20	95
TOTAL	92	70	41	203

The observed x^2 value was 0,75 which is less than 5.99; d.f = 2; $p < 0,05$. Accordingly there appears to be no significant relationship between the degree of information obtained and the preference for such information, i.e. patients received less information than they preferred. The degree of relationship between these two variables, based on the contingency coefficient test was 0,052.

10.11.2. Right to Choose

It appeared from responses to question 21 that 77 respondents consult with more than one general practitioner. Thirty-one respondents stated that different members of the family preferred different doctors; 28 stated that they went to either one of the general practitioners who was not perceived to be too busy, while 18 indicated other reasons such as 1)

"they preferred a second opinion in some cases" and 2) "they went to a doctor that was available at the time that suited them."

H18 Private medical patients should not be able to consult specialists without referral by general practitioners.

Alternate: Private medical patients should be able to consult specialists without referral by general practitioners.

Although 40 (29.2%) respondents indicated that patients should be referred to specialists by their general practitioners, 97 (72.9%) respondents believed that they should be free to consult a specialist without referral by a general practitioner. The binomial test produced a value of 5.29. Since it is greater than the critical value of 1.645 at the 0,05 level of significance the null hypothesis could be rejected in favour of the alternative. Their reasons for a direct consultation with specialists are indicated below.

TABLE 10.30: REASONS FOR DIRECT CONSULTATION WITH SPECIALISTS

REASONS	RANK	NUMBER OF RESPONDENTS
1) Patients are aware that the general practitioner does not have the necessary diagnostic equipment and tests	1	58
2) Patients feel an unnecessary consultation fee is paid to the general practitioner who merely gives him a note of referral	2	41
3) Patients know that they need the specialist's advice and that they have to wait for long periods at the general practitioner's office just to be given a letter of referral	3	33

The total for these reasons exceed 99 since some respondents provided more than one reason. Although there is no prohibition on specialists with regard to treating patients who have not been referred by general practitioners, there is nevertheless, a prohibition on members of medical aid schemes who may want to consult with specialists directly. Medical aid patients, who constitute the majority in this survey are bound by a rule [rule K No.12896 of the Government Gazette 14-12-90 :10] which states:

"Save in exceptional cases, the services of a specialist shall be available only on the recommendation of the attending general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists."

This rule restricts the patient's choice and increases the cost of attending to the illness because a "double payment" is made for the treatment of an illness which the patient knows, requires the services of a specialist.

The issue of direct consultation with a specialist for non-medical aid members seems to be controversial among some general practitioners who believe that the specialists should not exclude the general practitioner from the chain of patient management care since the system "has worked to both our benefits and to the ultimate benefit of our patients. Some general practitioners believe that they should be informed about "preoperative exigencies," or that they "should be asked to assist at the operation." Moreover they believe they are more aware of the patient's total medical history and their non-specific problems which could have a significant bearing on the procedures to be adopted. [SAMJ 1985:67:749]. Although, this may be a valid point, patients should in terms of accepted consumer rights be accorded the right to make their own decisions in this regard.

10.11.3. Patients' Responsibility to Complain

H19 Private medical consumers do not complain about their unpleasant experiences.

Alternate: Private medical consumers complain about their unpleasant experiences.

10.11.3.1. Dissatisfaction

Dissatisfaction with doctors is believed to be communicated by word of mouth to friends and family in view of the absence of an association that is perceived to act in the patient's interests.

Table 10.31. depicts the number of respondents who complain about their general practitioners and specialists to various categories of people.

TABLE 10.31: DISSATISFACTIONS COMMUNICATED TO OTHERS

CATEGORIES OF PEOPLE COMPLAINED TO	GENERAL PRACTITIONERS	SPECIALISTS	TOTAL
The doctor himself	40	13	53
Friends	46	18	64
Family	21	7	28
OtherS	6	4	10
TOTAL	113	42	155

Based on these responses the null hypothesis that private medical consumers do not complain about their unpleasant medical experiences, was subjected to a chi-square test. A value of 1.12 was obtained, which is less then the critical value of

7.82; d.f = 3; $p < 0,05$. Consequently, the null hypothesis could not be rejected. A pertinent point to consider in this regard is that only those who indicated that they were dissatisfied (i.e. 53 with their general practitioners and 21 with their specialists) responded to this question.

Results have also shown that 31 respondents out of 53 [58.5%] who were dissatisfied with their general practitioners per se continue to consult with them infrequently, 9 out of 53 [16.98%] continue to consult with them always, while 13 [24.5%] indicated that they do not consult with doctors with whom they have previously been dissatisfied. Apropos specialists, 21 respondents indicated that they were dissatisfied with their specialist per se. Of these 9 [42.86%] continue to consult with them infrequently; 3 [14.29%] continue to consult with them always while 9 [42.86%] do not consult with them as a result of their dissatisfaction.

Question 25 addressed the issue of whether patients discouraged friends/family from going to doctors with whom they were dissatisfied. Table 10.32 presents their responses.

TABLE 10.32.: DISCOURAGEMENT OF FRIENDS AND FAMILY IN THE EVENT OF DISSATISFACTION

RESPONDENTS	GENERAL PRACTITIONERS	SPECIALIST	TOTAL
Not applicable	11	30	41
Never had the experience but would do so	60	35	95
Sometimes	30	15	45
Always	23	15	38
Never	9	4	13
TOTAL	133	99	232

Answers to question 26 indicate that 52 (39.1%) respondents believed that their friends and/or families followed their advice; 3 (2.25%) believed that friends/families did not follow their advice, while 59 (44.36%) were uncertain in view of the fact that they had no need to advise their friends/family since they did not experience any dissatisfaction.

10.11.3.2. Medical Negligence/Malpractice

H20 Private medical consumers believe that the SAMDC protects them adequately through their disciplinary processes.

Alternate: Private medical consumers do not believe that the SAMDC protects them adequately through their disciplinary processes.

Despite the fact that an evaluation of professional services is difficult to assess given the wide informational chasm that exists between medical professionals and patients and the very

intangible nature of instantaneous production and consumption of such services, it is nevertheless not difficult for some to distinguish between gross negligence and malpractice on the one hand and the ordinary performance of medical services on the other.

Nineteen respondents (14.28%) believed that they were victims of negligence/malpractice, while another 17 (12.78%) were unsure. The question of what constitutes negligence/malpractice is also very academic, given the wide range of application of the rule of 'reasonable care". Moreover in the case of medical products and services, many respondents were not aware of exactly what their rights are. Accordingly, they were unable to objectively and categorically state that their rights were infringed. Thus the large number who indicated that they were unsure.

Respondents' awareness of their ability to complain to the South African Medical and Dental Council (SAMDC), in respect of problems encountered with their doctors, was addressed in Question 28a. A large proportion 55 (41.35%) were unaware of their right to complain to the only official regulatory body for medical professionals in South Africa. Indeed the response to question 28b revealed that 86 respondents (64.66%) did not have sufficient knowledge of the SAMDC even though 24 of these respondents indicated that they were aware of the fact that they could complain to the SAMDC. It also appeared that only 27 respondents (20.30%) were of the opinion that the SAMDC protects patients adequately through their disciplinary process. 20 believed that the SAMDC did not protect patients adequately while the majority 86 (64.66%) were unable to comment because they indicated that they did not know enough

about the SAMDC to comment on their functions. The binomial large sample sign test was used to test the null hypothesis that private medical consumers believe that the SAMDC protects them adequately through their disciplinary processes. Since the test produced a value of 6.85 which is greater than 1.645 at the 0,05 level of significance, the null hypothesis must be rejected in favour of the alternative.

However, all the medical practitioners (in the second phase of the study) believed that the SAMDC protected the patients adequately. Indeed they believed that the SAMDC applied its rules too stringently against doctors. Non-white doctors even mentioned that they "believed that the SAMDC treated them more unfairly than their White counterparts."

Table 10.33 reflects the statistics of patients who believed that they were victims of medical negligence. The actions pursued by these patients thereafter, are also reflected in Table 10.33.

TABLE 10.33: ACTIONS TAKEN BY THOSE WHO BELIEVED THEY WERE VICTIMS OF MALPRACTICE/NEGLIGENCE

	YES	NO
Awareness of right to complain to SAMDC	12	7
No. who complained to SAMDC	1	18
Unsatisfactory response from SAMDC	1	0
Patients who sued doctors for malpractice	0	19
Patients who considered suing doctors for malpractice	3	16
Patients who experienced difficulty in obtaining assistance from other doctors	3	16

Of the 19 patients who considered themselves victims of negligence/malpractice, only 12 were aware of their right to complain to the SAMDC. However, only 1 actually complained to the SAMDC and received an unsatisfactory response. This patient also considered legal action against the doctor, as did two other victims. Indeed this patient indicated that he experienced difficulty in obtaining assistance from other doctors, which was necessary to discharge the burden of proof (of negligence) which rests on the plaintiff. Evidently this constitutes an impediment to the process of redress. Consequently none of the respondents actually brought legal actions against their doctors. Incidently, the respondent who initiated the available actions, in an attempt to seek redress, is a Professor in an allied field of medical care. It is hardly surprising that others who are generally less influential, do not undertake such actions.

Although this might be construed as a lack of initiative as regards the right to redress, the reasons for this apparent apathy are formidable as may be recalled from Chapter 6. Data acquired during the second phase of the empirical study bore testimony to this fact, and indeed exposed another startling aspect. A senior member of one of the professional societies, observed that the lack of action on the part of victims, is to some extent due to threats by the doctor perpetrating the negligent act. Victims and/or their families were apparently threatened that they would not receive medical treatment from doctors/specialists, since the "guilty doctor" would inform his colleagues about the victim (a form of blacklisting). This aspect was not formally researched in this study. However some confirmation was received from a prominent attorney who specializes in medical malpractice cases. His letter, attached as appendix H, attests to the refusal of a specialist to treat the family of a victim who had initiated a malpractice action against another member in the medical profession.

In this instance, the specialist was one of only two in his speciality in this town, and such a refusal certainly constituted a threat to the patient, since vital medical treatment could be needed at any time by any member of the family.

This letter which was included in a report by the specialist to the referring doctor, was handed to the patient who was to deliver it to her doctor. The patient read the contents of this report and promptly handed a copy of it to her attorneys, who were instructed to refer the matter to the SAMDC.

A further impediment to the process of redress is the fact that the victim has to discharge onus of proof i.e. he has to prove beyond any doubt that the doctor was negligent, and he cannot do this without the assistance of an expert doctor in that particular speciality. Victims have had great difficulty in securing the co-operation of experts in the medical field to assist in discharging onus of proof, as may be evidenced from the example of the Professor previously cited in this study. Although the victim was a professional in a related field of medicine, he nevertheless had difficulty in securing the assistance of a doctor in the field in which the negligence was perpetrated.

It is also believed that the courts in the RSA are reluctant to find in favour of the plaintiffs in an attempt to prevent the situation which presently exists in the USA, where vast sums are awarded to victims of malpractice. Much time, money and effort are also wasted in the USA on frivolous cases brought by plaintiffs who see litigation as a means of "getting wealthy overnight". Consequently, malpractice insurance rates have soared in the USA. The threat of malpractice claims has caused some physicians in the USA to practice defensive medicine, whereby they deliver their services on the assumption that the patient will sue. This has resulted in physicians ordering more tests and consultations with less reliance on their professional judgement. Of course more tests and consultations result in higher health care costs, and increasing malpractice insurance premiums are recovered through increased health care fees. The vicious cost spiral is perpetuated. Although the US courts consider many more malpractice cases than do the South African courts, the judicial procedure, is nevertheless rigorous.

Hospitals too, may be legally liable under the doctrine of corporate negligence for the malpractice of physicians providing care in hospitals. Evidently the principle of vicarious liability applies here as well.

10.11.4. Right to be Educated

H21 Private medical consumers do not prefer to know about the medicine that has been prescribed for them.

Alternate: Private medical consumers prefer to know about the medicine that has been prescribed for them.

A large proportion of respondents (121) or 90.98% expressed their desire to know about the medicine that they are using. A binomial large sample sign test was implemented to test the null hypothesis that patients do not prefer to know about the medicine that is prescribed for them. Since the observed value of 9.44 is larger than the critical value of 1.645 at the 0,05 level of significance, the alternate hypothesis is accepted.

The reasons for the desire for an awareness about the medicine is presented in Table 10.34.

TABLE 10.34.: RESPONDENTS PREFERRING TO KNOW ABOUT MEDICINES FOR VARIOUS REASONS

REASONS	RESPONDENT	%	RANK
To determine whether they are allergic to it	74	55.64	3
To know what precautions to take	75	56.39	2
To be able to tell other doctors/ specialists about it	97	72.93	1
To know whether they have the medication at home, before purchasing more of it	72	54.14	4
Other	9	6.77	5
	327		

The total exceeds 133 because most respondents cited more than one reason for wanting to know the name of the medication. The most frequent reply in the "other" category was that "they just wished to be knowledgeable about medicines and what illnesses they are indicated for, so that they could engage in self medication. However, some medical aid schemes have not until 1991, permitted benefits for self-medication. These benefits, however, are still construed as being woefully insufficient. Medical aid benefits for self-medication could discourage patients from consulting with general practitioners for minor ailments, which could result in reduced consultation costs.

In an attempt to improve knowledge and communication on prescription medicines, the National Council on Patient Information and Education (NCPIE) of the USA, sponsored a campaign in 1986 on medication information. The Council outlined the fact that patients must be informed about the names of medication, the dosage, the period over which the medicine should be taken, what foods, medicine or activities should be avoided while taking the medicine, the side effects and what should be done if they occur, as well as any other relevant information about the medicine.

Rudd and Glantz (1989:268) have observed that

> "studies of patient desire for health information suggest that there is great and often unfulfilled interest in information regarding health and medical care. Several investigations have demonstrated that patients are generally dissatisfied with the amount of information they receive from their physicians."

They also believe that such information can exert discipline on the health care market-place and increase physician and hospital accountability.

In the Federal Republic of Germany, for example,

> "The patients right to information and the physician's duty to provide such information had to e imposed upon the medical profession by law". (Francke 1989:295).

One hundred and twenty six respondents (94.74%) in this study indicated that they should be told about the possible adverse effects of medicines, while 106 (79.7%) stated that they should also be informed about the possible risks of surgery or treatment. Only 76 (57.14%) believed that their general prac-

titioners informed them sufficiently with regard to the risks of surgery or treatment, while 63 (47.37%) believed that their specialists informed them adequately on these issues.

H22 Doctors and pharmacists do not inform their patients adequately about medication.

Alternate: Doctors and pharmacists inform their patients adequately about medication.

Tables 10.35, 10.36 and 10.37 present the responses of patients with regard to information received from general practitioners, specialists and pharmacists on various aspects of medication.

TABLE 10.35: INFORMATION ON DOSAGE

FREQUENCY	GP	%	SP	%	PH	%	TOTAL
Sometimes	32	24.06	26	19.55	24	18.05	82
Always	84	63.16	54	40.60	10	0.75	148
Never	2	1.50	2	1.50	3	2.26	7
TOTAL	118		82		37		237

TABLE 10.36.: INFORMATION ON ADVERSE EFFECTS

FREQUENCY	GP	%	SP	%	PH	%	TOTAL
Sometimes	51	49.30	33	33.84	38	38.86	122
Always	47	48.08	32	33.00	40	37.90	119
Never	20	20.61	16	14.15	15	16.24	51
TOTAL	118		81		93		292

TABLE 10.37.: INFORMATION ON PRECAUTIONS

FREQUENCY	GP	%	SP	%	PH	%	TOTAL
Sometimes	43	41.38	25	27.24	32	31.38	100
Always	56	55.45	37	36.5	41	42.05	134
Never	21	23.17	17	15.26	18	17.57	56
TOTAL	120		79		91		290

The total in each column in each table varies because respondents received different degrees of information on different occasions from each category of provider. Evidently information was not consistently provided on each of the aspects to all the respondents.

Table 10.38 presents a cumulative result of dosage precautions and adverse effects by general practitioners, specialists and pharmacists, in order to facilitate the implementation of a chi-square test.

TABLE 10.38: FREQUENCY OF INFORMATION ON DOSAGE, PRECAUTIONS AND ADVERSE EFFECTS BY GENERAL PRACTITIONERS, SPECIALISTS AND PHARMACISTS

FREQUENCY	GP	SP	PH	TOTAL
Sometimes	126	84	94	304
Always	187	123	91	401
Never	43	35	36	114
TOTAL	356	242	221	319

The chi-square test was implemented to test the null hypothesis that doctors and pharmacists do not inform their patients adequately about medication. A value of 8.06 was obtained which is less than 9.49; d.f = 4; $p < 0,05$. Accordingly the null hypothesis cannot be rejected.

H23 Private medical consumers do not initiate actions to redress problems pertaining to medical products and services.

Alternate: Private medical consumers initiate actions to redress problems pertaining to medical products and services.

The hypothesis that patients do not initiate actions to redress problems pertaining to medical products was addressed in question 37. Table 10.39 presents the responses that were received when patients were asked about the actions they took when adverse reactions resulted after the use of medicines.

TABLE 10.39: FREQUENCY OF ACTIONS UNDERTAKEN BY RESPONDENTS IN THE EVENT OF ADVERSE REACTIONS

REPORTED TO	SOMETIMES	ALWAYS	NEVER	TOTAL
Doctor	17	68	3	88
Specialist	10	43	1	54
Pharmacist	5	23	5	33
TOTAL	32	134	9	175

Although 40 respondents (30.08%) indicated that adverse reactions had not occurred, the total nevertheless exceeds the number of respondents in the "always" category. The reason for

this is that patients reported to more than one party in the health care management chain and sometimes to different members on different occasions.

The observed chi-square value was 8.56 which is less than 9.49: d.f = 4; $p < 0,05$. Thus the null hypothesis, that patients do not initiate actions to redress problems regarding medical products cannot be rejected.

The types of recourse available to those who reported adverse reactions are presented in Table 10.40.

TABLE 10.40: RECOURSES AVAILABLE TO RESPONDENTS IN THE EVENT OF ADVERSE REACTIONS

RECOURSES AVAILABLE	G.P.	SPECIALIST	PHARMACIST
The medicine is exchanged for another	3	0	2
The medicine is taken back and the patient is refunded	5	3	4
Patients are asked to continue using medicine with precautions which were not mentioned before	35	21	6
Patients are asked to come for further consultations	13	8	2
Other	5	3	4

The response rate to this question appears to be low for different categories since respondents could only follow the advice of one member of the medical chain per incident, even

though they may have reported to more than one member of the medical chain for each incident. The most frequently mentioned recourse was that patients were asked to continue using the medication with precautions which were never mentioned initially. The failure of doctors and pharmacists to initially inform patients of certain precautions, clearly leads to unnecessary discomfort for some patients. It therefore seems that greater attention needs to be paid by doctors and pharmacists to this issue.

On the other hand, the medical advisor to a pharmaceutical company (a member of the sample in the second phase), commented that the response of humans to medicines, both in terms of efficacy and adverse reactions is never entirely predictable since there will always be a multiplicity of factors that can precipitate various reactions. Accordingly, the occurrence of adverse reactions cannot be ruled out completely for any medication. In this regard, it is interesting to note that the Medicines Control Council, a regulatory authority in South Africa, whose duty is to "serve the public interest in the regulation and control of matters pertaining to the quality, safety and efficacy of medicines", (Folb et.al. 1988; 28 : 772) has established a national system for collating and monitoring adverse drug reactions. This is essentially a post marketing drug surveillance system. It is considered to be vital despite the rigorous marketing tests that are conducted. The premarketing process consists of preclinical animal testing, followed by three phases of clinical testing. Phase I is usually conducted on non-patient volunteers; phase II involves administration of a drug to a small number of selected patients; and phase III is the final premarketing test of the drugs, safety and efficacy. These trials have major limita-

tions, such as restricted patient populations, limited duration of patient exposure and limited patient numbers. Considerable information remains unknown after the end of phase III testing, including less common adverse effects; delayed adverse effects; efficacy and toxicity in types of patients usually excluded from premarketing, e.g. children, pregnant women and old people; efficacy and toxicity in patients with other illnesses (Fassihi and Robertson : 1990: Vol.77; 577).

Medical professionals and pharmacists are encouraged to advise the Medicines Control Council about drugs that cause adverse reactions. The information is used for the development and maintenance of a comprehensive record of adverse drug reactions which may be accessed by pharmacists both locally and internationally. Of the 14 doctors interviewed, 11 indicated that they report previously unknown adverse reactions to the pharmaceutical companies concerned. It is interesting that the doctors reported their experiences to the pharmaceutical companies rather than the Medicines Control Council. Perhaps the procedure for reporting to the Medicines Control Council is perceived to be too cumbersome. Pharmaceutical manufacturers are usually informed via their representatives who call on doctors. This practice is clearly not conducive to an effective post-marketing surveillance system.

10.11.5. The Right to Safety

10.11.5.1. Samples of Medications

The provision of samples together with the medicine to facilitate testing for allergic reactions is held to be a means of reducing the total cost of medical care to patients,

since many patients cannot presently return and reclaim the cost of medicines that cause adverse reactions. Instead they have to outlay additional amounts to procure other medicines to serve their needs. Should a sample prove to be unsafe, the unused and unopened medicine can be returned or exchanged for a safer alternative.

A representative of the PSSA believed that such an arrangement would be too cumbersome for pharmacists and doctors. More importantly, some returned medicines would lose effectiveness or be unsaleable, particularly those medicines which are vulnerable to temperature changes. It was suggested instead that a sample of potentially hazardous medicines should be administered directly by the doctor or pharmacist. Should there be no ill effects, the balance of the medicine would then be supplied normally. However, such a procedure would be cumbersome for both pharmacist and doctor on the one hand, and the patient on the other, since he/she would need to visit the doctor/pharmacist twice for one medication.

Inevitably patients are exposed to a degree of risk when they take different types of medication for the first time. Being fore-warned about the possible side effects tends to pre-empt any claim for liability against the pharmaceutical company despite the fact that the product may be widely advertised within medical and pharmaceutical circles as being effective in alleviating or curing a certain medical condition.

Sixty four respondents (48.1%) felt that only some medicines should be accompanied by samples (i.e. those that are potentially very dangerous); 47 respondents (35%) felt that all

medications should be accompanied by a sample for first time users; while 22 respondents (16.5%) felt that no medicines should be accompanied by samples.

Of the 22 respondents who indicated that medicines should not be accompanied by samples, 5 believed that the costs of medication would increase, 8 believed that the possibility still existed that products could be tampered with, thus making them unsafe, and 9 believed that the medicine could become ineffective because of incorrect storage.

Prices would probably increase due inter alia to the additional packaging costs involved, but perhaps respondents felt that it would be less costly in the long term to have to pay for a sample than to pay for the full quantity which has to be thrown away, plus an alternative replacement. In some instances samples of medications are provided by manufacturers to doctors to test on their patients. However allegations were made by some respondents that these samples are often sold by doctors to their patients, thus defeating the purpose. An executive member of the Pharmacy Council suggested that doctors should buy medications and conduct tests on patients before prescribing potentially dangerous products. This would obviate the need for samples together with individual units of medication.

H24 Private medical consumers do not believe that they should be allowed to return and be reimbursed for medicines that cause adverse reactions.

Alternate: Private medical consumers believe that they should be allowed to return and be reimbursed for medicines that cause adverse reactions.

The majority of patients, 105 (78.9%), believe that they should be reimbursed for medicines that cause adverse reactions.

The binomial large sample sign test produced a value of 6.67. Being larger than the critical value of 1.645 at the 5% level of significance, the alternative hypothesis that patients believe that they should be allowed to return and be reimbursed for medicines that cause adverse reactions, should be accepted.

The respondents concerned believed that the following costs should be reimbursed if medicines cause adverse reactions.

TABLE 10.41: COSTS TO BE REIMBURSED IN THE EVENT OF ADVERSE REACTIONS

	NUMBER OF RESPONDENTS
Cost of medicines only	36
Costs of medicines plus the cost of attending to the adverse reactions	69
TOTAL	105

Despite the fact that consumers are accorded the right to return unsatisfactory commercial goods and be reimbursed for them, patients are unlikely to achieve this right in respect of medicines, unless they can prove that the manufacturer was negligent. An executive member of the S.A. Pharmacy Council stated that the Council had not expressed its views on this issue. But he felt that patients should not be allowed to claim from the manufacturer, since the manufacturer warns of

possible adverse reactions in the information leaflet which accompanies the medication. However, a common practice among pharmacists and doctors is to remove this information leaflet before dispensing the medication, making it impossible for the patient to learn anything about the medication. This is done in the belief that some patients would be so intimidated by the warnings that they would not take their medication at all. In this regard, the executive member of the Pharmacy Council stated that "patients should be allowed to claim from doctors and pharmacists who do not inform patients of the potential dangers, since it is their duty, if they should remove the leaflets." He further observed that:

> "Patients who are adequately informed should not have any recourse since, medications do not fall in the same category of commercial products and risk is an inevitable consequence."

A representative of the Pharmaceutical Society of South Africa (PSSA) observed that in order to reduce the possibility of adverse reactions, all pharmacists and doctors should keep a record of products that have caused adverse reactions to different patients, so that they could avoid prescribing or dispensing products that have the possibility of causing adverse reactions to those patients. It would also lead to an efficient system of dispensing by the pharmacist and dispensing doctor.

10.12. ADVERTISING

H25 Private medical consumers do not believe that doctors should be allowed to advertise.

Alternate: Private medical consumers believe that doctors should be allowed to advertise.

The prohibition on advertising by professionals has been gradually lifted for various categories of professionals. Attorneys and auditors are now permitted to advertise within certain ethical constraints. However, medical professionals are still not allowed to advertise in any way.

One hundred and twelve respondents (84.21%) believed that doctors should be allowed to advertise, while 21 believed that the status quo should remain. Eighty three of the 112 respondents felt that advertising would lead to better knowledge about their doctors while 50 respondents felt that it may result in price competition which would be to their advantage. Of the 21 respondents who indicated that doctors should not be allowed to advertise, all felt that it would result in confusion, while 19 of them also believed that it would result in higher prices since the cost of advertising would have to be borne by the patients eventually.

The binomial large sample sign test produced a value of 7.89 which is larger than the critical value of 1.645 at the 0.05 level of significance. Thus the alternative hypothesis that private patients believe that doctors should be allowed to advertise, should be accepted.

Table 10.42 reflects the kinds of information that respondents would like to see in the advertisements.

TABLE 10.42: RESPONDENTS' DESIRE FOR VARIOUS TYPES OF INFORMATION

TYPES OF INFORMATION	NUMBER OF RESPONDENTS	RANK
Whether the doctor dispenses medication	13	6
The doctor's speciality/expertise	21	2
Hours and days of consultation in different locations if he has more than one surgery	21	2
The doctors' after hours policies	19	5
The doctors' fees	20	4
All of the above	76	1
Other	2	7

Of the 112 respondents, 76 (67.85%) of them, wished to be informed of all the relevant types of information. Although all the respondents did not indicate that they wanted to be informed of all the aspects, they each nevertheless indicated that they wanted to know about 2 aspects at the very least.

On the other hand, during the second phase of the survey, 79.36% of doctors (11 out of 14) indicated that advertising should not be allowed. Of the 11, 7 felt that ethical standards would be compromised by any effort to compete. All 11 felt that the present system of "word of mouth" advertising by patients and doctors was sufficient.

One specialist, a psychiatrist, felt that advertising would be useful since specialists are usually situated in medical centres together with many others and therefore their specialities need to be made known via advertising.

The most surprising fact revealed in this phase was that only one doctor considered advertising from the point of view of the patient, and said that advertising was necessary to facilitate an awareness of the rights of the patient. This Black doctor was perturbed by the high incidence of non-communication of facts to the patient by their attending doctors. According to this doctor, private Black patients are often not even informed of what their illnesses are. Controlled, ethical advertising could be of great benefit to patients.

10.13. SERVICE QUALITY PERFORMANCE

10.13.1. Waiting Time

H26 Private medical consumers do not become annoyed when they have to wait for long periods to be attended after arriving punctually for their appointments.

Alternate: Private medical consumers become annoyed when they have to wait for long periods to be attended after arriving punctually for their appointments.

Specialists, almost always consult with their patients on an appointment basis. Some general practitioners however, do not permit their patients to make appointments to consult with them. In this study 28 respondents (21.05%) were not allowed to make appointments. While 105 (78.95%) were permitted to do

so. Surprisingly, of all the respondents, 23 (17.29%) preferred not to make appointments. These results are tabulated in Table 10.43.

TABLE 10.43.: PREFERENCE FOR MAKING APPOINTMENTS

RESPONDENTS PERMITTED TO MAKE APPOINTMENTS	RESPONDENTS WHO PREFER TO MAKE APPOINTMENTS		
	YES	NO	TOTAL
YES	88	17	105
NO	22	6	28
TOTAL	110	23	133

Of the 28 respondents who are not permitted to make appointments 22 would actually prefer to make such appointments with their general practitioners. A high percentage of medical practitioners in this study (78,57%), were of the opinion that general practitioners who do not permit appointments do so for economic reasons: more patients can then be seen during peak periods by reducing the time spent with each. It was also observed that such general practitioners do not respect the fact that their patients' time is also of some significance. One specialist remarked that "they (the general practitioners) believe that only their time is sacrosanct."

Three general practitioners interviewed did not permit their patients to make appointments and they have no intention of doing so, despite the fact that their patients often wait for long periods before being attended to.

It should however, be noted that 3 of the general practitioners who do permit patients to make appointments complained that they often "do not turn up for their appointments". The need for some patient education is clearly evident here.

Table 10.44 presents the perceptions of patients on the adherence to appointment times by their practitioners after having arrived punctually themselves.

TABLE 10.44: ADHERENCE TO APPOINTMENT TIMES BY PRIVATE PRACTITIONERS

	G.P.	SPECIALIST
Sometimes	56	44
Always	20	23
No	29	32
TOTAL	105	99

The average waiting time before attendance by doctors and specialists is indicated in Table 10.45. These figures include those respondents who are not permitted to make appointments.

TABLE 10.45: AVERAGE WAITING PERIOD AT PRIVATE PRACTITIONERS' OFFICES

TIME PERIOD	G.P.	SPECIALIST
Less than 15 minutes	37	26
15 minutes - 30 minutes	51	34
30 minutes - 1 hour	37	30
1 - 2 hours	6	6
More than 2 hours	2	3
Total	133	99

The sentiments expressed by those who wait to be attended to by their doctors is presented in Table 10.46.

TABLE 10.46: SENTIMENTS OF RESPONDENTS WHO ARE MADE TO WAIT

SENTIMENTS	RESPONDENTS
Annoyed	80
Don't mind	47
Afraid of contracting other diseases while waiting	6
Other	4
	137

The total exceed 133 since some respondents indicated more than one sentiment.

The null hypothesis that private medical consumers do not become annoyed when they are made to wait for long periods after arriving punctually for their appointments was subjected to a binomial test.

A value of 2.34 was obtained which is greater than the critical value of 1.645 at the 5% level of significance. Accordingly the alternate hypothesis may be accepted.

While 80 respondents (60%) become annoyed when they have to wait for long periods, it is evident that some patients are more understanding, realising that emergencies do arise and that it is difficult to plan for such situations. Nonetheless, many of the "don't mind" respondents agreed that doctors' schedules are generally poorly planned despite the fact that there are no emergencies.

For many patients who are employed, time translates into money, just as it does for the doctor. Moreover, waiting time that extends beyond the time allowed by an employer for a doctor's consultation, causes anxiety among many patients. In this regard, the Women's Bureau, was planning to inform the medical profession via a letter to the South African Medical Journal, that it is receiving a growing number of complaints from working women. They complain that they have to take time off from work to visit their doctors, and then have to waste time waiting for long periods despite having arrived punctually for their appointments.

The President of the Women's Bureau commented:

> "it is clearly understood that illness cannot be arranged but it is respectfully submitted that improved planning, with some respect for other peoples time, would help."

Some concerns were expressed by patients about consultations with their doctors. These concerns are reflected in Table 10.47.

TABLE 10.47: PATIENTS' CONCERNS ABOUT THEIR DOCTOR

	RESPONDENTS	
	NUMBER	PERCENTAGE
He might not have washed his hands after treating other patients	36	27.06
He might use needles that have been used on others	40	30.08
His equipment might not be sterilized	37	27.82
Other	3	2.26
Total	116	87.22

These concerns are not surprising in the light of the highly contagious nature of some diseases.

An assistant professor of paediatrics who presented her findings on handwashing in a paediatric intensive care unit, at the American Society for Microbiology's Interscience Conference on Antimicrobial agents and Chemotherapy, found that "overall, physicians, nurses, occupational/physical therapists, respiratory therapists and radiology technicians wash their hands only 30% of the time between patient contacts. Although nurses washed their hands significantly more often than physicians - 37% of the time compared to 21% - their rate leaves much to be desired. In fact physicians washed their hands less frequently when wearing an overgown, 'with the

thought being possibly that they felt somewhat protected. They're not washing their hands for the patient's sake'." (Medical Chronicle - April 1987 p.2)

It has also recently been revealed in the USA that the dentist's drill is a potential health hazard because it can transfer the (Aids) HIV virus to other patients (Sunday Times - 21-7-91 : 5).

10.13.2. Accessibility

10.13.2.1. Accessibility to Specialists

Most respondents indicated that they experienced some difficulty in making appointments for urgent medical attention. Table 10.48 reflects this.

TABLE 10.48: DIFFICULTY OF SECURING APPOINTMENTS WITH SPECIALISTS

DIFFICULTY EXPERIENCED	NUMBER OF RESPONDENTS	%
Sometimes	60	45.1
Always	11	8.3
Never	28	21.1

The difficulty of securing appointments appears to stem from a wide disparity between the limited supply of specialists and the great demand by patients for such services.

10.13.2.2. Telephonic Accessibility

H27 **Private medical consumers can easily consult with their doctors by telephone in order to clarify doubts and obtain results.**

Alternate: Private medical consumers have difficulty in clarifying doubts and obtaining results by telephone.

Telephonic accessibility also appears to be difficult as may be seen from Table 10.49.

TABLE 10.49: ACCESSIBILITY OF DOCTOR BY TELEPHONE

ACCESSIBILITY BY TELEPHONE	DOCTOR	%	SPECIALIST	%	TOTAL
Never accessible	13	9.8	24	24.2	37
Sometimes	69	51.9	55	55.5	124
Always accessible	51	38.11	20	20.2	71
TOTAL	133	100	99	100	232

The null hypothesis that private medical consumers do not have difficulty in consulting with their private practitioners by telephone in order to clarify doubts and obtain results, was subjected to a chi-square test. The observed value was 13.7 which is greater than 5.99; d.f = 2 $p < 0,05$. Accordingly the alternative hypothesis may be accepted.

The reasons for telephone calls do not appear to be frivolous from the responses in Table 10.50 Respondents indicated more than one reason for calling their doctors on various occasions. The reasons are ranked from 1 - 5.

TABLE 10.50: RESPONDENTS' REASONS FOR TELEPHONE CALLS

REASONS FOR TELEPHONE CALL	NO. OF RESPONDENTS	RANK
To find out about results of tests that doctor asked patients to undergo	82	1
To elicit more information regarding illness	75	2
To report on allergic reaction of medicine/treatment	38	3
To ascertain directions for use of medicine	24	4
Other	2	5
Total	221	

The total exceeds 133 since respondents provided more than one reason for calling their doctor. It appears that doctors generally ask patients to telephone them to ascertain the results of pathological tests that they have asked their patients to undergo. It is not surprising therefore that the majority of patients call their doctors for this purpose. However, many of them are unable to ascertain these results, even after repeated calls. To subject one's body to tests that the doctor orders and never to be able to ascertain the results of such tests certainly leaves much to be desired.

The general response to the question of whether a doctor's "busyness" is justification for not answering or returning a call to a bona fide patient, is presented in Table 10.51.

TABLE 10.51: RESPONDENTS' PERCEPTION OF PRACTITIONERS' NON-RESPONSE

JUSTIFICATION FOR NON-RESPONSE BECAUSE OF BUSYNESS	NO. OF RESPONDENTS
Not justified	55
Sometimes	67
Always justified	11
Total	133

The majority of respondents i.e. 78 (58.65%) appear to understand that the doctor is justified at least sometimes, in not responding to patients' telephone calls, because of his "busyness". However, a courteous practice may be to inform patients via his/her secretary/assistant, where test results are negative. This could allay the anxiety of patients, and obviate the need for repeated calls from the patients.

10.13.3. Overservicing

H28 Private medical consumers do not believe that their practitioners overservice.

Alternate: Private medical consumers believe that their practitioners overservice.

A patient's ability to assess the need for pathological tests, or other diagnostic procedures, is severely hampered by his/her lack of knowledge of medical science. Nevertheless, some patients, despite their limited knowledge, have indicated that they still considered certain procedures which were requested by their doctors to be unnecessary.

TABLE 10.52: PERCEPTIONS OF PROCEDURES REQUESTED UNNECESSARILY

UNNECESSARY PROCEDURES	RESPONDENTS
Unnecessary Pathological Tests	22
Unnecessary Medications	32
Unnecessary X-Rays, Scans	15
Unnecessary Induced Labours	8
Unnecessary Epidurals	4
TOTAL	81

These procedures may be construed as over-servicing, and each of these activities unnecessarily adds to the total cost of medical care. Indeed 57% of medical practitioners (in the second phase of the study) stated that over-servicing of medical aid patients was a significant form of abuse of medical aid benefits by doctors. The implementation of the binomial test produced a value of 3.04, which is greater than the required 1.645 at the 0,05 level of significance. Accordingly the null hypothesis could be rejected in favour of the alternative.

With regard to over-servicing through unnecessary medications, the following points made by Straughan J.L. (1987 at the 55th Congress of MASA) should be noted carefully:

Doctors should:

"* recognise that many disorders are essentially self-limiting, and may well improve at least as well without the administration of any medicines as with their use - in fact, it may well occur that medicines introduce new problems or implications;

* recognise that many medicines are not better than a placebo, but that few are nearly as safe; and

* have an awareness that many medicines are not justifiable in terms of their constituents, dosage, vagueness of indications and side effects."

A greater awareness of these factors, it is hoped, would stem an inclination toward overservicing.

10.14 THE CENTRAL NULL HYPOTHESIS

Having established that some of the subsidiary null hypotheses were rejected while others could not be rejected on the basis of the statistical tests, it is now possible to determine whether or not the Central Null hypothesis can be rejected.

The Central Null hypothesis that consumers of private medical products and services are satisfied with the present system of private medical care is a function of the variables that were tested under the subsidiary hypotheses. As may be recalled from chapter 8 the normative model suggests that PS = f(PR, MM, DPR, FO, PI). [Patient satisfaction is a function of favourable outcomes in respect of Patients' Rights (PR), the

Marketing Mix (MM), the Doctor-Patient Relationship (DPR), Facilitative Organisations (FO) and Protective Institutions (PI)].

It is possible to apply the T sign test by, for example, assigning a negative sign (-) to the null hypotheses that were accepted and a positive sign (+) to those that could not be accepted. Neutral hypotheses (H1, H3, H21 and H23) would need to be omitted.

For convenience the results of the relevant hypotheses are indicated by negative and positive signs in Table 10.53.

TABLE 10.53: RESULTS OF HYPOTHESES

	NULL NOT REJECTED	NULL REJECTED
H2		+
H4	-	
H5		+
H6		+ *
H7		+
H8		+
H9		+
H10		+
H11	-	
H12		+
H13		+
H14		+
H15		+
H16		+
H17		+ *
H18		+
H19	-	
H20		+
H22	-	
H24		+
H25		+
H26		+
H27		+
H28		+

*Negative sign changed to positive to render direction of results consistent with the other tests.

Explanation of Test

The parameter of the sign test is = T.

The formula to be used is $Px(x) = 24Cx(0.5)^{x}(0.5)^{24-x}$

$= 24Cx(\frac{1}{2})^{24}$

n = 24 since there are 24 relevant hypotheses

20 hypotheses were in the hypothesized direction while 4 were not.

$$P[T \leq 4] = \frac{24C_0 + 24C_1 + 24C_2 + 24C_3 + 24C_4}{2^{24}}$$

$$= \underline{0,0008}$$

If $P[T \leq 4] < 0,025$ the null hypothesis could be rejected.

If $P[T \leq 4] > 0,025$ the null hypothesis may be accepted.

Significance level is 0,025 since it is a two tailed test.

Since $P[T \leq 4] = 0,0008$ which is less than 0,025, the Central null hypothesis can be rejected in favour of the alternate which states that consumers of private medical products and services are dissatisfied with the present system of private medical care.

10.14. SUMMARY AND CONCLUSION

The majority of respondents in this study emerged from a "middle-class" socio-economic background. At least 85% were in the middle and higher income classes: 75.57% were matriculated, while 49.7% of these had post matric qualifications.

Patients revealed a tendency to consult general practitioners of the same racial groups as themselves. However, there appeared to be some tendency to patronize specialists of other race groups.

The majority of respondents i.e. 133 (97%) received private medical treatment, while 36 (27%) of these received both private treatment as well as state subsidized health care.

When preferences for systems of delivery were probed, 99 [72.3%] respondents preferred the establishment of a National Health Service. However in the absence of a National Health Service, 107 [78.1%] preferred private medical treatment, especially since 96 [72%] respondents are members of medical aid schemes.

Eighty two, (66.7%) of the respondents who are predominantly private medical care users, were willing to use state subsidized facilities should conditions improve substantially.

Private patients indicated that they were satisfied with the service provided by private practitioners. However, there were other factors related to service conditions which negatively affected the perceptions of the respondents independently of the actual treatment by their doctors.

Despite the perceived satisfaction of the treatment received, 48.9% of the respondents, believed that the primary objective of private practitioners was to make as much money as possible.

The most important reason cited for the use of private medical care was the compulsory medical aid membership of employed respondents: 44 medical aid members (45.8%) did not prefer medical aid membership. Moreover, the preference for medical aid membership was not significantly related to household size or household income.

There was a high degree of awareness by both medical aid members and doctors, of medical aid abuse by patients and doctors. In addition the majority of members did not recognise the medical aid schemes as their representative organisations.

The establishment of a patient's association drew much support from the respondents: 104 respondents (78%) favoured such an association.

The general perception of respondents was that private medical care costs are excessive and that consultation fees ought to be based on a number of different factors.

The majority of respondents wished to be informed about their practitioners' specialities and policies; the risks of treatment and surgery, and the relevant details about prescribed medication. However, they believed that they were not adequately informed with regard to these essential aspects and that their options for recourse were extremely limited.

Private patients who experienced some form of dissatisfaction complained to the doctors themselves, to their friends and to their families. Nevertheless, the majority of those who experience some form of dissatisfaction continue to consult the same practitioners.

Patients who believed that they were victims of negligence or malpractice had experienced great difficulty in attempting to redress their injustices.

The majority of respondents believed that they should be accorded the right to safety and the right to be reimbursed, especially with regard to prescribed medication which caused unexpected reactions.

With regard to waiting time, the majority of patients who arrived punctually for their appointments, became annoyed when they had to wait for more than fifteen minutes for attention.

The majority of respondents also experienced difficulty in clarifying doubts and obtaining pathological test results by telephone.

Respondents also believed that there was a tendency towards overservicing by private practitioners.

The final analysis revealed that private medical patients were dissatisfied with the delivery of private medical care.

CHAPTER 11

CONCLUSIONS AND RECOMMENDATIONS

11.1. INTRODUCTION

The primary focus of this study was to ascertain whether patients were satisfied with the system of delivery of private medical care.

Subsidiary focal points were to establish whether the rights and responsibilities acknowledged in progressive medical care systems were applied to the private medical sector; and whether practitioners could effectively utilize the traditional marketing mix in contributing towards patient satisfaction.

In order to achieve these objectives, it was necessary to delineate the main determinants of patient satisfaction against the background of the literature survey.

The measurement of patient satisfaction, however, is complicated by the fact that satisfaction depends on individual levels of aspiration or expectations, as well as on the individual's perception or evaluation of outcomes. Patient satisfaction was operationally defined within the context of the disconfirmation of expectations paradigm. In this instance, consumer's prior expectations are compared with actual perceptions of performance as the service is being received. When expectation exceeds performance, dissatisfaction results; when expectations are met or exceeded, satisfaction results.

11.2. DETERMINANTS OF PATIENT SATISFACTION

The normative model suggested that patient satisfaction was dependent upon a constellation of interdependent and interacting variables. Quality evaluations were not made solely on the outcome of services; they also included evaluations of the process of service delivery.

Twenty four of the twenty-eight hypotheses were tested to perceive whether or not patients in this survey were satisfied with the delivery of private medical care.

Upon an analysis of the empirical study, it was found that twenty of the relationships predicted in the model were in the hypothesized direction. The consequent rejection of the Central Null Hypothesis suggests that there is an extremely high potential for the manifestation of this dissatisfaction, possibly in the form of medical consumerism.

Although the causes of medical consumerism are inherent within the present system of private medical care, the absence of mobilizing forces and the absence of communicative and advisory structures, have confined the effects to individual dissatisfactions, rather than a collective countervailing force. However, it is logical to expect that within an increasingly educated and consequently assertive society, consumers will begin to assert their rights more vociferously.

11.2.1. Patients' Rights and Responsibilities

According to the normative model an acknowledgement of patients' rights and their concomitant responsibilities were stipulated as being vital steps towards judicious assessments and legitimate expectations of performance quality, which in turn, would determine positive or negative disconfirmation. The results suggested that these rights were not significantly recognised or acknowledged by private medical care providers.

11.2.1.1. The Right to Safety

The normative stipulation that products and treatment should be safe when used as prescribed, seems to be compromised since 69.9% of the respondents indicated that adverse reactions had occurred as a result of the prescribed use of medical products registered by the Medicines Control Council (MCC). Despite the fact that the Medicines Control Council registers medicines that are, in its opinion, "safe and efficacious", it nevertheless, recognises the potential of

some medicines to cause adverse reactions amc

Adverse reactions are never entirely predictab.

the multiplicity of factors that can precipitate t

On the basis of the reportedly high incidence of adverse reactions of registered medicines, it may be assumed that the philosophy of registration of the MCC is based to a greater extent on accepting a broader margin of risk rather than on the criteria of absolute safety and efficacy.

Nevertheless, the MCC stipulates that medicines are required to be furnished with details pertaining to special precautions and possible side effects, so that users may be forewarned. However, information leaflets containing this vital information are often withdrawn before the medicines are dispensed to patients, since pharmacists and dispensing doctors believe that patients would refrain from consuming these products because of the intimidating, confusing and technical information contained therein.

In their desire for greater safety, the majority of respondents (83%) felt that at least potentially dangerous medicines should be accompanied by samples which may be used to test for adverse reactions. However, the participants in the second phase of the study considered this to be an untenable situation because it would result in cumbersome and protracted processes with a corresponding increase in the cost of dispensing.

Since patients are not permitted to claim reimbursement for drugs that cause adverse reactions, it appears that drugs are subject to less strict principles of liability than other products are. Yet the traditional claims from the industry about threats to the research and development of essential new drugs look less than convincing when substantial sums are spent on marketing drugs to doctors. Moreover, profits accrue to the manufacturers from the sale of products that have proven to be hazardous and sometimes fatal to consumers, without a corresponding compensation for such damages.

In implementing safety decisions, co-operation of legal experts, scientists and pharmaceutical manufacturers, should be secured. In addition the patient's interest in optimal drug safety should be a right of participatory decision-making. To this end, knowledgeable experts, authorized by patient organizations should be members of the advisory committee on medicinal product safety.

Medicinal product safety is a means of ensuring patient protection. It would be inevitable that some marketing interests of manufacturers will invariably clash with the interests of consumer protection. In this regard,

Glaeske (1989:367) also observed that

> "considerable economic interests are at stake in pharmaceutical production and that health and the need for information may clash with marketing concerns."

In respect of over the counter (OTC) preparations too, "pharmacists do not play the desirable role of active filters between the exaggerated promises and the realistic usefulness of OTC preparations. Their income is based on the

sales of medicines. The higher the sales, the higher their earnings. Under such circumstances, how could pharmacists be expected to advise their customers properly?" (Glaeske 1989:368).

Despite this, greater emphasis needs to be placed on the need for comprehensible information on medicines, their benefits and their risks which would enable consumers to engage in informed decision-making and responsible behaviour in the event of adverse reactions.

A patient's organisation may, in its efforts to reduce the information monopoly of manufacturers, and distributers, establish a data bank on adverse reactions of medicines and the circumstances under which they occur on the basis of consumer reports of such reactions.

An especially noteworthy data bank would be one that has information on the synergistic adverse effects of drugs when taken together with other drugs or certain types of food.

Consumers must, however, still be aware of the fact that although drug laws can set a framework for consumer protection, they cannot totally programme individual safety decisions. Consumers must therefore actively participate in ensuring that only drugs that are safe for them are used. This can only be ensured if more relevant information is provided to consumers by medicine manufacturers and practitioners.

11.2.1.2. The Right to be Informed

The normative stipulation was that patients should be adequately informed about the merits of their practitioners, about medicines and the risks of surgery and treatment. The results revealed that the practitioner's duty to provide information to patients in these areas has not been adequately implemented.

This research indicated that respondents preferred more information than they actually obtained from their practitioners. This appears to be consistent with findings of studies conducted over a period of 30 years, where patients

indicated that they wanted much more information about their diagnosis and treatment than they received, especially because of the risk involved (Rudd & Glantz 1989:268).

Murray (1991 : 10) also found that the greater the degree of perceived risk ... the greater the consumer propensity to seek information about the product or service. He also found that

> "Consumers appeared to use information or personal channels primarily in situations in which perceived risk and uncertainty have not been reduced sufficiently by formal information sources. Consumers acquire information as a strategy of risk reduction in the face of this specific uncertainty."

Consequently, it would be advisable for practitioners to spend more time in explaining and reassuring patients when risky procedures and/or treatment are envisaged for the patient. Moreover, information about serious or terminal illnesses should be made known to the patient with good judgement and must be based upon the patient's ability to accept such information.

As regards sources of information, respondents obtained information in respect of general practitioners mainly from friends (55.5%) and family (45.3%) while the chief but inadequate source of information about specialists was obtained from general practitioners (38%).

The results of this study are consistent with the findings by Rudd and Glantz (1989:267) in the USA, that consumers carried out only a limited information search prior to selecting a practitioner." In South Africa too, the general absence of information sources impacts significantly upon this research process.

The provision of pertinent information could also contribute towards cost containment, particularly where patients are urged to consider both quality and price in exercising their choice of practitioners. Rudd and Glantz (1989:258) have pointed out that employers and public agencies involved in financing health care have begun to introduce consumer information programmes as part of their cost containment ef-

forts, by providing information such as practitioners' specialities, their fee structures and their quality of care.

In addition to word of mouth advertising, such information about quality and cost should ideally be accessed from computerised data bases at accessible points such as medical aid offices, places of employment, or patient/consumer association offices.

These innovative cost containment initiatives may serve a dual purpose in that they could ensure improvements in quality while reducing costs.

Medical aid schemes too, should be instrumental in encouraging their members to verify charges and detect errors in statements, in an attempt to reduce unnecessary costs.

11.2.1.3. The Right to Choose

The normative stipulation is that patients should have the

right to choose among the available systems of delivery as well as among practitioners within the private sector.

Choice of private health care is fundamentally dependent on the patient's ability to pay.

Respondents in this study had a choice of state subsidized care, private medical care or a combination of these. The majority (89.8%) primarily patronized the private medical sector. The principle reason among 61.3% of the respondents for private sector patronage was that they were medical aid members.

However, 66.67% of the predominantly private patients indicated that they would choose state subsidized facilities if conditions improved substantially at these centres.

An overwhelming majority of respondents (72.3%) indicated that they would prefer the establishment of a National Health Service (NHS) in South Africa. This stems from a fear that with the escalating cost of private medical care, it would become unaffordable.

It was also clear that the different educational levels of respondents played no part in the overwhelming support for the NHS. The desire for the change in the system of health care delivery stems also from the desire for continued accessibility to health care.

As regards private medical care, consumers can exercise only a limited choice in the selection of general practitioners since they rely on "word of mouth" information only. The consumers' choice is further restricted in the selection of specialists, hospitals and pathological laboratories, since these are usually determined by the general practitioner.

However, this study revealed that the system of referral of specialists for medical aid members was construed as being a cumbersome and costly restriction of patient choice, particularly where patients were convinced that they needed the attention of a specialist.

Patients would be more inclined to adhere to the traditional network if they perceived that the general practitioner's role is indispensible in co-ordinating the expertise of specialists, so that omissions, overlaps, incompatible prescriptions and oversupply of drugs are avoided.

Since information and alternatives are limited, respondents in this study conducted a limited information search only, prior to selecting health care practitioners. Many of the respondents who were dissatisfied (75.5%) did not even switch doctors when they experienced dissatisfactions.

Andreasen (1985:140) has also observed that "Physician care is an area where supply restrictions and a lack of easily available information make it difficult for the ordinary consumer to switch doctors in cases of serious dissatisfaction. The switching option may however be available to persistent and knowledgeable consumers". If patient discontent becomes manifest, new health service structures would become inevitable. The extent to which they will be altered will

depend upon the strength of interest groups, the creative philosophies of the participants in the decision-making process and the ethics of health professionals.

11.2.1.4. The Right to be Heard

The patients' right to avail themselves of the opportunity to be heard by the relevant providers and statutory bodies, in order to improve their position vis-a-vis the providers of products and services was advanced as a normative criterion.

The patients' right to be heard is usually manifested in patient complaints to the providers themselves or to other facilitative channels.

If viewed in a constructive manner, patient complaints could play a vital role in assuring doctor-patient equity in an imperfect marketplace. Therefore more attention ought to be paid to the complaint process and the implications that it

has for providers. A communication-focused complaint response could assist both parties in a settlement of the dissatisfaction.

Generally it is assumed that face-to-face complaint encounters between doctor and patient may be difficult due to powerful informational advantages and the consequent authority relationships that presumably lead to assertive behaviour on the part of doctors. Complaint encounters would therefore be perceived as being more difficult in addressing a doctor-patient dyad.

The results of this study were surprising in the light of the assumed submissive role of patients, since the majority who experienced dissatisfactions with their practitioners, complained to the practitioners themselves. The most frequent "avenue" for complaints however, were "friends". In addition respondents often discouraged friends and family from consulting practitioners with whom they were dissatisfied (negative word of mouth advertising).

Only an insignificant minority complained to the South African Medical & Dental Council since the majority indicated that they were not entirely convinced that the SAMDC protected their interests adequately.

11.2.1.5. The Right to Education

The normative model requires an educated society that would facilitate a timeous identification and resolution of problematic situations that may arise in health care.

The present health system is paternalistic, and characterised particularly by limited information and limited patient participation in the decision-making process. Improved general education may positively impact upon health "literacy" and patient initiative.

Education could also facilitate a participative approach in health care management, which could hasten the recovery of the patient.

An overwhelming majority of respondents (93.6%) expressed a desire to know more about medical products and treatment in order to be more knowledgeable about medical care; and to be able to choose judiciously. A need to educate patients and the community in health matters stems from the need for individual initiative, independence and willingness to take responsibility for personal, family and community health (Kotze 1986:22).

The doctor is believed to be a pre-eminent figure in the educational task, since he is entrusted with the sovereignty of the patient and the promotion of healthful behaviour.

> "Creating an atmosphere of confidence, understanding and authority in his dealings; makes it possible for the doctor to fulfil his educational function as an integral part of his total medical task" (Kotze 1986:25).

The public media represent effective tools for the dissemination of health education, including an emphasis on preventive education. Preventive health education should also be

offered since patients will be encouraged to adopt healthful behaviour patterns which would be conducive to their well-being.

Health education becomes effective when it is sustained over a period and is co-ordinated. Moreover, it must address the needs of the target community.

Self care education programmes may also be implemented effectively through the media.

Studies of self-care education have revealed that they resulted in a true reduction in physician visits rather than delaying needed care or stimulating additional symptom recognition (Rudd & Glantz 1989:265). Self-care users have lower expenditures for hospital and physician services.

It must be noted, however, that more educated people are likely to become more critical towards the health service system with intensive calls for better understanding between patients and doctors and more meaningful dialogue with patient organizations.

In addition, greater knowledge and education in general is believed to lead to the ability to detect dissatisfactions. It would then become necessary for the medical profession itself to develop models of doctor-patient relationships which would meet the changing patient profile. Greater attention would need to be given to the development of these skills at medical schools.

11.2.1.6. The Right to Redress

The right to redress wrongs or injuries and to receive compensation for such injuries is a requirement of the normative model.

Patients addressed their different forms of dissatisfaction in various ways. The majority discouraged friends and family from consulting doctors with whom they were dissatisfied. Yet of the respondents who were dissatisfied with their practitioners, the majority of them continued to consult practitioners with whom they were dissatisfied.

This is consistent with the conclusion arrived at by Andreasen (1985:140) that local consumers will switch to alternative sources, while those who are not vocal will simply 'swallow' their dissatisfaction. Adverse reactions to medical products were reported to doctors, specialists and pharmacists at varying frequencies on different occasions. But actions taken in respect of alleged malpractice or negligence, was the lowest, presumably as a result of the respondent's perceived powerlessness against the medical sector, and certainly as a consequence of the onerous legal obligation of discharging the burden of proof, in a court of law. The discharging of the onus of proof is impossible without the expert testimony of other competent medical practitioners who are generally reluctant to assist the injured parties. In the absence of competent consumer/patient mediating structures, the resignation of many injured parties to the status quo, is the characteristic feature.

In an attempt to establish equity, the establishment of a No Fault Patient insurance system would serve to redress the damages suffered by patients.

The No Faulty Patient insurance system, as it is applied i. Sweden, covers damages that occur as a result of medical malpractice, negligence or damages that may be drug related.

The practical consequences of this system is

> "that patients are able to complain about clinical and other problems without launching criticisms against a particular person. Health services personnel seldom run the risk of lawsuits or find themselves at the mercy of outrageous publicity. The insurance is also a source of information on medical injuries in the population as well as on what procedures are especially venture-some" (Borgenhammer 1989:280).

The rationale of patient insurance is based on the abandonment of the traditional principle of liability based on malicious intent and negligence. In this instance, attention is focused on the injured person's need for compensation. Compensatory payments for damages should be based on standard amounts and should exclude insignificant injuries. Lest it be inferred that such a system would lead to greater incidence of negligence or malpractice because of the absence

of the punitive element, it must be pointed out that the existence of such a system, should not (and does not in Sweden) preclude the possibility of suing practitioners or pharmaceutical manufacturers for damages as a result of negligence or malpractice.

Furthermore, the right to compensation in the Swedish system is not prejudiced by the fact that the patient has been forewarned about other risks. The only significant point is whether or not a mishap has occurred which could have been avoided.

It may be suggested that class actions also, should be permitted against pharmaceutical drug manufacturers whose drugs result in serious injuries to many patients, and against practitioners who commit negligent acts on many patients.

The present South African legal system is not designed to allow class actions, where a large number of injured parties, seeking compensation for injuries caused through negligence or malpractice, may join together and institute legal proceedings in the form of a single action.

The absence of such a course highlights legal procedures which exacerbate difficulties rather than facilitate the resolution of disputes, at great cost to all parties.

11.2.2 Protection of Patient

The need for patient protection as a result of the imperfect market situation, was also advanced as a normative criterion.

In response to a recognition of the rights of patients, it is logical to expect some form of legal/statutory protection that would uphold these rights. Such legal protection is available in South Africa where serious infringements of patient rights may be addressed through recourse to the law of contract or the law of delict and/or disciplinary enquiries conducted by the SAMDC. Respondents who believed that they were victims of malpractice/negligence, however, did not undertake any form of litigation, although some of

them (15.8%) did consider taking this form of recourse. They were unable to proceed as a result of onerous legal requirements which were difficult to fulfil.

However, the only respondent who approached the SAMDC with regard to alleged malpractice/negligence was dissatisfied with the response from the SAMDC.

Of the 19 respondents who believed they were victims, 12 (63%) of them believed that the SAMDC does not protect them adequately through their disciplinary process, and consequently did not approach the SAMDC. The majority of respondents in this study were not aware of the role of the SAMDC.

The SAMDC's recent decision to inform complainants about the explanation provided by the doctor of his alleged misconduct (Sunday Times Extra 27/10/91:5) is a positive step towards equity and patient information. Another fundamental step towards the protection of patient interests would be the publication of the findings of every disciplinary enquiry where a doctor is found to be guilty of misconduct.

Patients would then be able to more clearly define what constitutes malpractice/negligence or misconduct. This would enable them to more readily address these issues when they arise. Secondly medical practitioners, in an attempt to avoid negative publicity, would be induced to adopt more acceptable patterns of behaviour that conform to the prevailing customs within a community.

11.2.3. Facilitative Organisations

The normative stipulation was that patients who experience difficulties in various areas should be able to gain access to facilitative organisations.

11.2.3.1. Financial Organizations

Although 73.96% of medical aid members acknowledged that financial organisations were necessary in order to receive private medical care, they believed that membership of such organisations should be voluntary and not a condition upon employment. At least 31.3% of members preferred not to be

members. There appeared to be no difference in preference for medical aid membership among the various income groups and among respondents with different household sizes.

An overwhelming proportion of both members (90.6%) and practitioners (95%) were aware of abuse of medical aids by members, practitioners and pharmacists.

Medical aid members (88.54%) also believed that medical aid schemes resulted in higher costs of medical care. In addition, they felt that medical aid schemes neither provided adequate financial cover, nor served as representative organisations with regard to medical problems.

Surprisingly though, 52.1% of members indicated that they would use the services of medical care practitioners to the same extent even if they were not medical aid members, contrary to a generally held belief that medical aid members consult doctors for trivial reasons. Only a relatively small proportion (17.5%) of medical aid members and other respondents held medical insurance policies to assist them in securing private medical care.

The assistance of financial organisations in the delivery of private medical care seems indispensible in an environment of rapidly escalating medical care costs. However, inefficiencies and abuse within these organisations must be addressed timeously in order to ensure their viability. With the advent of competing health care payment schemes, the competitive advantages of each scheme needs to be identified and promoted effectively, if the scheme is to enjoy any success.

The present frustration with the existing schemes could prompt a review of health maintenance organisations (HMOs), especially among entrepreneurs who wish to diversify into the health care sector. There are distinct possibilities for enterprises with the resources and skills necessary to provide health care efficiently and profitably. HMOs are "systems whereby hospitals, practitioners and other health care resources are incorporated in a single system which provides services to members for a premium paid in advance. Physicians are employees and are paid on a per capita basis rather than through a fee for service. Emphasis is on

prevention since the healthier the subscriber, the lower the cost of the organisation and the greater the reward for the physician" (Rathmell 1974:176).

HMOs could also serve as effective systems for encouraging preventive care and cost-effective treatment. A shift in emphasis to preventive care could result in a reduction of total health care costs. However, a criticism of this approach may be the question of whether or not savings would result from a vested interest in decreased services and less care, or from less costly and effective arrangements for supplying adequate care.

Comments can only be advanced after a comprehensive assessment of such organisations. However, this would be a pertinent point to consider if such organisations should be established in South Africa.

11.2.3.2. A Patients' Association

South African patients are not represented by voluntary groups, which could further the interests of patients,

provide information and advice to individuals or promote understanding and co-operation between patients and the medical sector. The establishment of such a facilitative association is overdue. A significant majority (78%) in this study preferred the establishment of a patients' association.

Patients' associations exist in Britain and Canada (which are served by a National Health Service) as well as in the USA where patients are predominantly served by private practitioners. Such an association in South Africa, could readily represent both state subsidized patients and private patients, since all health care recipients should be accorded the same rights.

Although the existing consumer organisations addressed some patient issues, their functions are limited, because patient issues are specialized and consequently require representatives who are well versed in the field of medical consumerism. Furthermore representatives of patients' associations should ideally participate in decision making with

regard to, inter alia, product safety, third party payment schemes, changes to local health services and medical experiments on patients.

In regard to alleged malpractice/negligence cases, the patients' association could assist patients in assessing whether or not they are justified in pursuing enquiries or securing compensation, on the basis of established precedents.

More significantly a patients' association could provide access to data banks on inter alia:- precautions to be taken in the case of drugs; information about practitioners and their particular specialities; and dissatisfactions experienced by patients in respect of drugs or services.

A patients' association could also, as a result of well organized information systems, simplify the consumers' decision task, and the search process, and assist in the reduction of costs incurred in the switching of practitioners as a result of dissatisfactions.

The behaviour of practitioners too could be significantly improved in an attempt to promote themselves to an increasingly discerning patient population who would have an avenue for the manifestation of their dissatisfactions.

11.2.4. The Service Marketing Mix

The elements of the marketing mix, at the disposal of practitioners, was stipulated as a normative set of criteria that could effectively contribute to patient disconfirmation.

The private medical care system in South Africa is in stark contrast to the conventional marketing model of enterprises. The medical service market is characterised by fragmentation of services, restricted markets affecting both supply and demand, imperfect knowledge on the part of buyers, the absence of mediating or advisory patient associations, barriers to entry through registration with a regulatory body and the curtailment of promotional activities.

This, however, does not preclude the application of marketing mix options in the delivery of private medical care.

Indeed, a proper understanding of marketing theory and practice by practitioners could result in the improvement of health care services in the following ways, viz:

* a recognition and acknowledgement of the rights of the consumer which could lead to an enhancement or reassertion of the "sovereignty of the patient";

* establishment of standards for maintaining good health, without a diminution of quality; and

* improvement through the use of techniques, without a dilution of the professional nature of health care.

This study assessed the extent to which these options could be implemented in a private medical care system.

11.2.4.1. Price

The existence of an equitable and flexible pricing policy was advanced as a normative consideration.

Prices played a passive role in the demand for services. When patients are members of medical aid societies, they generally do not question the prices charged, although 72.9% perceived the prices to be excessive in this study. The majority felt that prices should be based on various factors. Indeed the MASA guidelines on fee structures permits flexible pricing policies, but the perception among respondents is that pricing flexibility is not presently a marketing mix option. They felt that prices should be based on: time required to perform the service; types of diagnostic equipment used, nature of treatment and medication dispensed; and the patients' ability to pay.

Should competition become an issue among practitioners, pricing flexibility among others should provide opportunities for securing advantages vis-a-vis other private practitioners within the same speciality.

Practitioners should in addition recognise incentives for controlling costs without compromising quality in order to become competitive.

In an attempt to contribute to a more cost-effective private medical care system, practitioners should carefully assess the type and mix of diagnostic and therapeutic services that are necessary and cost-effective in each case. Overservicing by the doctor must be avoided and over-utilization by patients must be discouraged.

Practitioners should be cognizant of the fact that medical aid membership is not a justification for over-use of expensive medications, diagnostic investigations and unnecessary treatment. These place intolerable burdens on members who have to face membership fee increases periodically.

Responsible practitioners should, for example, discuss the clinical aspects of the patient's illness with colleagues in the relevant specialities, instead of subjecting patients to a battery of superfluous tests. This would result in a reduction of costs to the patient.

Since doctors are at liberty to exercise flexibility in setting prices for their services, due regard should be given to a multiplicity of factors in determining the fees to be charged, such that a perception of equity prevails.

11.2.4.2. Place

The normative consideration is that patients should have easy access to clean and pleasant medical facilities.

In the case of health services, the relative importance to the patient of performance, time and place utility, surpasses every other consideration, particularly in the case of emergencies. Consequently, the fact that 26.3% of respon-

dents could not receive assistance in emergencies at night and over weekends, produced some negative disconfirmation in these respondents.

Physical surroundings, as an inherent aspect of place, generally evokes images which provide cues for inferring the prestige of practitioners. With an increasingly sophisticated society, there is likely to be greater emphasis on prestige discrimination of various practitioners' offices and waiting rooms.

In this study physical surroundings was ranked second in importance out of seven attributes that were assessed.

With regard to location, services appear increasingly, to be performed in central locations. This centralized tendency points to overriding supplier considerations rather than dispersed demand considerations. This could contribute to a postponement of professional attention by consumers in outlying areas.

For proactive practitioners, the development of effective marketing programmes would also demand creativity in the use of locational advantages for the mutual benefit of practitioners and patients.

11.2.4.3. Promotion

As a normative stipulation patients should be made aware of criteria that would facilitate their decision-making processes.

Promotion plays a modest and rather inconspicuous role in private health care, primarily because of statutory prohibition on advertising by practitioners. "Word of mouth advertising" by friends and family (cumulatively 90%) was the principle medium of promotion in this study. The quality of word of mouth advertising depends fundamentally on the disconfirmation that patients derive from the service encounter.

Perceptions of favourable performance and sale of services lead to positive disconfirmation which in turn serve as

potent forms of promotion in addition to sustained doctor-patient dyads.

Practitioners should also recognize the value of courtesy and thoughtfulness of employees in their relations with patients, and should actively stimulate such behaviour. Respondents (37.5%) cited "kind and caring attitude of staff" as the third factor of importance in contributing to positive disconfirmation.

Practitioners' assistants must also be trained to serve as effective marketers by applying their knowledge and skills in a cost-effective manner, without compromising their quality of services. In this way practitioners can guard against poor human resource practices that could affect the perception of the total service encounter. The essence of achieving patient satisfaction is that each employee recognise the importance of his/her own role in the chain of events.

Patients, however, considered the existing methods of promotion to be inadequate. A significant majority (84.2%) felt

that practitioners should be allowed to advertise their services in the hope that it would lead to greater information about their doctors. Respondents (37.5%) also felt that it could lead to advantageous price competition. On the other hand a minority of respondents (15.8%) felt that advertising would lead to confusion while 14.3% believed that it would result in an increase in the cost of health care since the patients would have to absorb the increased cost as a result of advertising.

If advertising should be permitted as a promotional mix option, clear rules which are easy to supervise and rectify must be set. Advertising should be clear, correct and intelligible so that patient awareness and choice is facilitated.

On the other hand, providers of medical services in the second phase of the study (92%) did not prefer to advertise their services. They considered the present word of mouth advertising to be sufficient. However, the question of whether or not to advertise was considered from their point

of view only. An insignificant minority (4%) believed that advertising should be permitted because it would be in the interests of patients.

In an increasingly competitive situation, practitioners ought to view promotion as an integrated activity, which also seeks to achieve professional goals. In an attempt to promote healthful behaviour patterns, preventative methods should be encouraged in promotional campaigns.

11.2.4.4. Performance of Service

The normative stipulation was that individual service encounters which determine service quality should be managed and monitored to provide satisfaction.

Although service quality is difficult to define and measure, discerning consumers are nevertheless able to distinguish between obvious differences in quality. Only 44.5% were very satisfied with their general practitioners, 34.3% with their specialists and 22.6% with private hospitals. Only a small percentage indicated that they were not satisfied with their

general practitioners (5.8%) specialists (4.4%) and hospitals (8%). Favourable perceptions of quality of service performance, kind and caring attitudes of doctor and staff, contact intensity (availability) and proper explanation of diagnoses were associated with greater satisfaction. These results are consistent with the findings of studies quoted by Rudd and Glantz (1989:255) where they identified professional competence, personal qualities, kindness, understanding and cost convenience as dimensions of patient satisfaction. Cost convenience (the ability to secure medical services at reasonable rates) was not associated with satisfaction in this study since it was perceived to be excessive.

Although there is still insufficient information on patient evaluation processes, practitioners must take cognisance of consumer opinions about the quality of care since they are expected to play a vital role in the patients' quest for quality medical care.

Many factors are expected to impact upon the perception of service quality. Indeed the present research supports Andreasen's (1985:136) contention that:

"Consumers vary in their abilities to detect quality differences."

This study revealed that respondents who were more educated, experienced a greater degree of dissatisfaction than those who were not.

Andreasen (1985:137) also found that a higher degree of education and concern about medical care may be associated with an ability to detect dissatisfaction. More knowledgeable consumers also detect overservicing by doctors more easily. Adequate controls must be implemented to prevent overservicing. Reliance on sound ethical and moral principles is a positive step in this direction.

Other factors that impact significantly on service quality performance are waiting time, office hours and accessibility by telephone.

As regards waiting time, (60.2%) of patients became annoyed when they had to wait for more than 15 minutes after having arrived punctually for their appointments. Moreover 78.9% of respondents preferred to make appointments in the hope that

they would not have to wait for long periods before receiving attention. Some respondents (17.2%) were not permitted to make appointments with their general practitioners, although they would have preferred this.

Office hours varied among practitioners, particularly general practitioners, but is greatly restricted over weekends. Some respondents (26.3%) experienced difficulty in securing medical attention during emergencies and over weekends.

In an attempt to solve this, busy periods (utilization peaks) should be identified and an optimum number of staff should be available , especially in the case of partnerships or private clinics. Indeed, some doctors have established their utilization peaks and have responded by being available after normal office hours. Some respondents (32.4%) are able to consult their practitioners "after hours".

For emergencies and weekends, a skeleton staff should be accessible by telephone at least.

Accessibility by telephone reflects the degree of contact intensity. Only 29.2% of respondents were able to contact their practitioners by telephone whenever the need arose; 17% indicated that their practitioners were never accessible, while 53.7% gained access only occasionally.

Specialists were less accessible by telephone (20.2%) than were general practitioners (38.1%). Telephone accessibility assists in keeping the communication channels open and also exhibits a commitment to the relationship. "Efforts to stay in touch have been identified as a key determinant of relationship maintenance" by Crosby, Evans and Cowles (1990:71).

The judicious introduction of marketing mix options would result in the efficient utilization of resources, an enhancement of the professional nature of health care, a concerted effort against overservicing and a consequent reduction in the rate of cost increases.

Disequilibrium in the medical care marketplace may be reduced by expanding the number and increasing the responsibilities of paramedics and nurses especially for routine checks, i.e. restructure the product/service line in an attempt to more adequately and efficiently meet consumer needs.

11.2.5. The Doctor-Patient Relationship

The patient's perception of a well performed yet complex and dynamic role, that enhances the evaluation of the practitioner, and contributes to a sustained doctor-patient dyad was the normative stipulation.

The majority of respondents (51.1%) considered a favourable doctor-patient relationship to be the most significant factor that contributed to positive disconfirmation.

The execution of the marketing mix options impacts directly on this dyad. Consequently, the best predictor of a patient's continued patronage is the quality of the doctor-patient relationship in previous encounters. Thus a high ex-

pectation of future patronage would be dependent upon a favourable perception of the current relationship and vice-versa.

An important variable in establishing and maintaining a favourable relationship is an acknowledgement by the doctor of the patients' rights.

A denial or infringement of these rights could seriously affect this relationship since the patient surrenders his sovereignty to the doctor with an expression of confidence in his ability. Confidence stems from trust and the initiative for establishing this trust rests with the practitioners.

11.3. CONCLUSION

Private medical care patients were dissatisfied with the system of delivery, although the majority were satisfied with the services of their practitioners per se. The dissatisfaction with the system of private medical care has a potential for the manifestation of medical consumerism.

However, the absence of mobilizing forces has resulted in a failure to present a countervailing force.

In increasingly educated and competitive systems, consumers will begin to assert their rights more vociferously through mediating structures.

The general impression of the survey was that studies of patient disconfirmation have significant implications for the marketing mix options of practitioners. If practitioners were to adopt the societal-marketing concept in health care, then the supremacy of the patient will be asserted, his rights acknowledged, his attitudes ascertained, and standards of acceptable performance will be established.

It appears that a re-establishment of the rapport and trust that once existed between doctor and patient could contribute significantly to the erosion of the perception by patients that the main objective of private practitioners is profit maximization.

The study also revealed that complex and strategic issues must be recognised, resolved and managed if the total service encounter is to be satisfactory.

Finally these findings imply that it is imperative for practitioners to demonstrate continued attention to qualitative outputs in order to maintain enduring relationships.

11.4. SUGGESTIONS FOR FUTURE RESEARCH

Research in the field of professional services is still in its infancy.

It is hoped that the present study will prompt further research on the decision-making processes associated with the purchase of professional services.

The research suggested that consumers' disconfirmation is influenced by a number of significant variables. It is possible to modify or extend the patient satisfaction model advanced in this study to other professional areas.

The robustness and boundaries of this model may be assessed by exploring other consequences and antecedents in the medical care sector that are perceived to impact on satisfaction.

Further research is needed to assess the extent to which professional practitioners in various fields recognize the applicability of the marketing mix options and whether or not they are implemented.

Research is also needed to assess how professional practitioners redress wrongs, their motivations for pursuing various courses of action and whether they voluntarily disclose acts or omissions that are potentially harmful to their clients.

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APPENDIX A

CONSTITUTION OF THE SOUTH AFRICAN CO-ORDINATING CONSUMER COUNCIL

DEFINITIONS

In this Constitution, unless the context otherwise indicates:

(a) "Chief Executive Officer" means the officer intended in paragraph 8;

(b) "Councillors" means the members of the Consumer Council;

(c) "Consumer Council" means the South African Co-ordinating Consumer Council;

(d) "Management Committee" means the committee intended in paragraph 8; and

(e) "Minister" means the Minister of Economic Affairs and Technology.

NAME

1 (a) The South African Co-ordinating Consumer Council.

(b) The name of the Consumer Council in the

/....

other official language of the Republic is -

Die Suid-Afrikaanse Koördinerende Verbruikersraad.

MAIN OBJECTIVE

2 The main objective of the Consumer Council is the furtherance, promotion and protection of interests of consumers in the Republic.

LEGAL PERSONALITY

3 The Consumer Council -

(a) is non-profit seeking;

(b) exists independent of changes in its membership; and

(c) is the bearer of rights and obligations, including ownership, independent from its members,

and is therefore a legal person.

AMENDMENT OF THE CONSTITUTION

4 (a) Amendments to the Constitution of the Consumer Council are effected by way of a majority decision at a general annual meeting of the Consumer Council or a special meeting of the Consumer Council convened for that purpose.

(b) An amendment intended in paragraph (a), becomes effective after the Minister has approved such amendment.

TRANSITIONAL ARRANGEMENT

5 Anything lawfully done or executed in terms of a former constitution of the Consumer Council shall remain lawful and of force and effect and shall be deemed to have been done or executed properly in terms of this Constitution.

DISSOLUTION OF THE CONSUMER COUNCIL

6 The Minister may by notice in the Gazette, dissolve the Consumer Council and determine the manner in which the assets of the Consumer Council shall be disposed of.

COMPOSITION OF THE CONSUMER COUNCIL

7 (1) The Consumer Council consists of sixteen members appointed by the Minister on the following basis:

(a) Nine members from a panel of not less than twelve names submitted to him by the South African National Consumer Union, and selected by that Union on the ground of their knowledge of consumer affairs and the contribution they can make in the interest of the consumer.

(b) Not more than four other members appointed by the Minister on the basis of their particular involvement in consumer affairs and in this regard the Minister may consult with those organisations which he deems fit for this purpose.

(c) A representative of the South African Bureau of Standards.

(d) A representative of the Department of Trade and Industry.

(e) A representative of the Department of sp. Agriculture Economics and Marketing.

(2) The Minister may fill a casual vacancy on the Council as follows:

(a) In the case of members appointed in terms of subparagraph (1)(a) by appointment from a panel of five names to be submitted to him by the South African National Consumer Union.

(b) In the case of members appointed in terms of subparagraph (1)(b) to subparagraph (1)(e), by personal appointment.

(3) The term of office of a member appointed in terms of subparagraph (1) expires at the end of the period for which the member was appointed, should the member reach the age of sixty-eight years during the term of office. Such a member shall not be eligible for re-appointment.

(4) A member appointed for the first time in terms of subparagraph (1) may not be more than sixty years of age.

(5) The Minister, in consultation with the Consumer Council, designates one member as chairman and one member as vice-chairman of the Consumer Council.

(6) Should the chairman for any reason not be able to perform his duties or should the position of chairman be vacant, the vice-chairman or a member of the Consumer Council designated by the meeting shall act as chairman.

(7) The Minister may on the request of the Consumer Council, or if he deems it expedient, appoint a person for a specific purpose as an additional member of the Consumer Council on the conditions and for the period that the Minister may

determine.

(8) A member of the Consumer Council -

(a) shall hold office for such period, but not exceeding three years, and on such conditions as the Minister may determine at the time of his appointment;

(b) who is not in the full-time service of the State, shall in connection with the activities of the Consumer Council be paid such remuneration and allowances as the Minister may determine with the concurrence of the Minister of Finance;

(c) shall vacate his office if he resigns as a member or if the Minister at any time terminates his period of office as a member if, in the opinion of the Minister, there are sound reasons for doing so; and

(d) may be reappointed at the expiry of his period of office by effluxion of time.

(9) (a) Subject to the provisions of paragraphs 11, 12 and 13 -

(i) the meetings of the Consumer Council shall be held at such times and places as the chairman may determine; and

(ii) the person presiding at a meeting of the Consumer Council shall determine the procedure at the meeting.

(b) No proceedings of the Consumer Council shall be invalid by reason only of the fact that a vacancy existed in its membership or that a member was not present during the proceedings or any part thereof.

(10) The administrative functions of the Consumer Council shall be performed by officers of the Consumer Council.

POWERS OF THE CONSUMER COUNCIL

8 The Consumer Council may -

(a) with the approval of the Minister appoint, suspend or dismiss a Chief Executive Officer and likewise determine his powers and duties, remuneration and allowances and demand security from him as may be necessary;

/....

(b) appoint managers, secretaries, other officers, clerks, agencies and employees for full time or part time service as it deems fit and likewise suspend or dismiss them, determine their powers and duties, determine their remuneration and allowances and demand that they furnish security as may be necessary;

(c) with the approval of the Minister acquire fixed property and dispose thereof;

(d) with the approval of the Minister, ensure the compliance with any contract or undertaking entered into on behalf of the Consumer Council, whether by means of a mortgage bond or other encumberance of any or all the property of the Consumer Council;

(e) with regard to the affairs of the Consumer Council, institute legal action or defend any action instituted against the Consumer Council or settle or waive any of the above-mentioned actions;

(f) issue receipts in connection with money paid to the Consumer Council;

(g) determine who may enter into any juristic act on behalf of the Consumer Council;

(h) invest any money of the Consumer Council, not immediately required for its purposes, with the Corporation for Public Deposits or with the approval of the Minister in any other manner deemed to be in the best interests of the Consumer Council;

(i) open and conduct bank accounts on behalf of the Consumer Council;

(j) subject to the provision, of this Constitution, perform any act to promote the objectives of the Consumer Council;

(k) in particular act as trustees or administrators of grants or bequests which are entrusted to the Consumer Council for the promotion of its main objective;

(l) with approval of the Minister, make available bursaries and study-loans upon such conditions and subject to such requirements as the Minister may deem fit;

(m) (i) with the approval of the Minister, appoint a Management Committee, comprising of at least three members of the Consumer Council of which one shall be appointed as chairman;

(ii) delegate any power granted to it by this Constitution to the Management Committee or empower the Management Committee to execute any duty which is accorded to the Consumer Council by this Constitution either in general or in a particular matter or in matters of a particular nature; and

(n) constitute any other committee which it may deem fit.

DUTIES OF THE CONSUMER COUNCIL

9 The Consumer Council shall -

(a) *mutatis mutandis,* keep accounting records as prescribed by section 284 of the Companies Act, 1973 (Act 61 of 1973);

(b) keep the accounting records as intended in paragraph (a) -

(i) at the Head Office of the Consumer Council or

at such other place or places as the Consumer Council may deem fit; and

(ii) available for councillors at all reasonable times;

(c) appoint auditors;

(d) as soon as possible after the end of every financial year on 31 March, present the audited accounting records of the Consumer Council, and a report of the activities of the Consumer Council during that year, to the Minister; and

(e) keep records of -

(i) all appointments by it of the Chief Executive Officer, managers, secretaries, clerks, officials and other employees of the Consumer Council;

(ii) the names of councillors who are present at each meeting of the Consumer Council; and

(iii) all decisions during meetings of the Consumer Council.

FINANCES OF THE CONSUMER COUNCIL

10 The Consumer Council, for the execution of its functions, is financed by -

(a) funds allocated by Parliament;

(b) funds obtained by way of donations or grants which the Consumer Council may accept from any organization or person as it deems fit; and

(c) own funds which derive from the execution of its functions.

MEETINGS

11 The Consumer Council shall hold an annual general meeting in every year within six months after the termination of the financial year of the Consumer Council.

NOTICE OF GENERAL MEETINGS

12 (1) An annual general meeting must be convened by written notice of at least twenty-one intervening days.

(2) Any other general meeting shall be convened by

written notice providing not less than fourteen intervening days.

(3) A notice intended in this paragraph -

(a) shall not include the day of delivery or the day it is deemed to have been delivered;

(b) shall indicate the venue, day and time of the meeting; and

(c) shall be issued -

(i) in the manner described in this paragraph or in such other manner as may exist, as prescribed by the Consumer Council at a general meeting; and

(ii) to the persons who are entitled in terms of this Constitution to receive such notice from the Consumer Council.

(4) Notwithstanding the provisions of this paragraph and regardless of the fact that a meeting of the Consumer Council is convened by a shorter period of notice, such a meeting shall be deemed to have been properly

convened should a majority of councillors have previously so agreed.

PROCEEDINGS AT AN ANNUAL GENERAL MEETING

13 (1) The notice of an annual general meeting, as intended in paragraph 12, shall be accompanied by the agenda and copies of the audited annual financial statements.

(2) The agenda for the annual general meeting shall at least provide for the following matters to be dealt with -

(a) the annual financial statements; and

(b) the appointment of auditors.

QUORUM

14 The quorum for all meetings of the Council shall be as follows:

(a) In the case of an equal number of councillors, one half of the full membership of the Council; or

(b) in the case of an unequal number of councillors, an absolute majority.

In the event of an equality of votes on any matter, the chairman shall also have a casting vote in addition to his deliberative vote as a member of the Council.

/....

REGIONAL OFFICES

15 (1) With the approval of the Minister, the Consumer Council may establish a regional office for any region of the Republic.

(2) The functioning of a regional office shall be governed by the Consumer Council.

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APPENDIX B

QUESTIONNAIRE

1. Are you aware of what consumerism is?

2. Do you view consumerism as an opportunity or threat to your firm?

3. Do you believe that the firm's response to consumerism increases the cost of marketing?

4. Is there a consumer department within the firm which deals with consumer complaints/queries?

5. What is your firm's concept of societal responsibility?

6. Please indicate areas in which your firm assists society in general.

APPENDIX C

A RETAILER'S CONSUMER BILL OF RIGHTS

We believe that:-

* The Customer - is THE MOST IMPORTANT PERSON in our Store.

* The Customer - is DOING US A FAVOUR by shopping at our Store.

* The Customer - should receive THE MOST PROMPT, COURTEOUS AND ATTENTIVE TREATMENT we are able to give.

* The Customer - should BE TREATED AS WE WOULD WISH TO BE TREATED OURSLEVES with friendliness and good manners.

* The Customer - should receive HONEST AND PROFESSIONAL ADVICE at all times.

* The Customer - should HAVE HER WANTS SATISFIED and we will help her to the best of our ability.

* The Customer - is entitled to freely EXCHANGE OR CREDIT MERCHANDISE if she is not entirely satisfied.

* The Customer - is entitled to have COMPLAINTS AND PROBLEMS DEALT WITH TO HER SATISFACTION, promptly, courteously and effeciently.

* The Customer - is NOT SOMEONE TO ARGUE WITH - if we make a mistake we will admit it and rectify it.

* The Customer - should receive that LITTLE EXTRA SERVICE OR HELP whenever there is the opportunity to do so.

UNITED NATIONS

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APPENDIX D

General Assembly

Distr.
GENERAL

A/RES/39/248
16 April 1985

008227

Thirty-ninth session
Agenda item 12

RESOLUTION ADOPTED BY THE GENERAL ASSEMBLY

[on the report of the Second Committee (A/39/789/Add.2)]

39/248. Consumer protection

The General Assembly,

Recalling Economic and Social Council resolution 1981/62 of 23 July 1981, in which the Council requested the Secretary-General to continue consultations on consumer protection with a view to elaborating a set of general guidelines for consumer protection, taking particularly into account the needs of the developing countries,

Recalling further General Assembly resolution 38/147 of 19 December 1983,

Noting Economic and Social Council resolution 1984/63 of 26 July 1984,

1. Decides to adopt the guidelines for consumer protection annexed to the present resolution;

2. Requests the Secretary-General to disseminate the guidelines to Governments and other interested parties;

3. Requests all organizations of the United Nations system that elaborate guidelines and related documents on specific areas relevant to consumer protection to distribute them to the appropriate bodies of individual States.

106th plenary meeting
9 April 1985

Annex

GUIDELINES FOR CONSUMER PROTECTION

I. Objectives

1. Taking into account the interests and needs of consumers in all countries, particularly those in developing countries; recognizing that consumers often face imbalances in economic terms, educational levels, and bargaining power; and bearing in mind that consumers should have the right of access to non-hazardous products, as well as the right to promote just, equitable and sustainable economic and social development, these guidelines for consumer protection have the following objectives

(a) To assist countries in achieving or maintaining adequate protection for their population as consumers;

(b) To facilitate production and distribution patterns responsive to the needs and desires of consumers;

(c) To encourage high levels of ethical conduct for those engaged in the production and distribution of goods and services to consumers;

(d) To assist countries in curbing abusive business practices by all enterprises at the national and international levels which adversely affect consumers;

(e) To facilitate the development of independent consumer groups;

(f) To further international co-operation in the field of consumer protection

(g) To encourage the development of market conditions which provide consumers with greater choice at lower prices.

II. General principles

2. Governments should develop, strengthen or maintain a strong consumer protection policy, taking into account the guidelines set out below. In so doing, each Government must set its own priorities for the protection of consumers in accordance with the economic and social circumstances of the country, and the needs of its population, and bearing in mind the costs and benefits of proposed measures.

3. The legitimate needs which the guidelines are intended to meet are the following:

(a) The protection of consumers from hazards to their health and safety;

(b) The promotion and protection of the economic interests of consumers;

(c) Access of consumers to adequate information to enable them to make informed choices according to individual wishes and needs;

/...

(d) Consumer education;

(e) Availability of effective consumer redress;

(f) Freedom to form consumer and other relevant groups or organizations and the opportunity of such organizations to present their views in decision-making processes affecting them;

4. Governments should provide or maintain adequate infrastructure to develop, implement and monitor consumer protection policies. Special care should be taken to ensure that measures for consumer protection are implemented for the benefit of all sectors of the population, particularly the rural population.

5. All enterprises should obey the relevant laws and regulations of the countries in which they do business. They should also conform to the appropriate provisions of international standards for consumer protection to which the competent authorities of the country in question have agreed. (Hereinafter references to international standards in the guidelines should be viewed in the context of this paragraph.)

6. The potential positive role of universities and public and private enterprises in research should be considered when developing consumer protection policies.

III. Guidelines

7. The following guidelines should apply both to home-produced goods and services and to imports.

8. In applying any procedures or regulations for consumer protection, due regard should be given to ensuring that they do not become barriers to international trade and that they are consistent with international trade obligations.

A. Physical safety

9. Governments should adopt or encourage the adoption of appropriate measures, including legal systems, safety regulations, national or international standards, voluntary standards and the maintenance of safety records to ensure that products are safe for either intended or normally foreseeable use.

10. Appropriate policies should ensure that goods produced by manufacturers are safe for either intended or normally foreseeable use. Those responsible for bringing goods to the market, in particular suppliers, exporters, importers, retailers and the like (hereinafter referred to as "distributors"), should ensure that while in their care these goods are not rendered unsafe through improper handling or storage and that while in their care they do not become hazardous through improper handling or storage. Consumers should be instructed in the proper use of goods and should be informed of the risks involved in intended or normally foreseeable use. Vital safety information should be conveyed to consumers by internationally understandable symbols wherever possible.

11. Appropriate policies should ensure that if manufacturers or distributors become aware of unforeseen hazards after products are placed on the market, they should notify the relevant authorities and, as appropriate, the public without delay. Governments should also consider ways of ensuring that consumers are properly informed of such hazards.

12. Governments should, where appropriate, adopt policies under which, if a product is found to be seriously defective and/or to constitute a substantial and severe hazard even when properly used, manufacturers and/or distributors should recall it and replace or modify it, or substitute another product for it; if it is not possible to do this within a reasonable period of time, the consumer should be adequately compensated.

B. Promotion and protection of consumers' economic interests

13. Government policies should seek to enable consumers to obtain optimum benefit from their economic resources. They should also seek to achieve the goals of satisfactory production and performance standards, adequate distribution methods, fair business practices, informative marketing and effective protection against practices which could adversely affect the economic interests of consumers and the exercise of choice in the market-place.

14. Governments should intensify their efforts to prevent practices which are damaging to the economic interests of consumers through ensuring that manufacturers, distributors and others involved in the provision of goods and services adhere to established laws and mandatory standards. Consumer organizations should be encouraged to monitor adverse practices, such as the adulteration of foods, false or misleading claims in marketing and service frauds.

15. Governments should develop, strengthen or maintain, as the case may be, measures relating to the control of restrictive and other abusive business practices which may be harmful to consumers, including means for the enforcement of such measures. In this connection, Governments should be guided by their commitment to the Set of Multilaterally Agreed Equitable Principles and Rules for the Control of Restrictive Business Practices adopted by the General Assembly in resolution 35/63 of 5 December 1980.

16. Governments should adopt or maintain policies that make clear the responsibility of the producer to ensure that goods meet reasonable demands of durability, utility and reliability, and are suited to the purpose for which they are intended, and that the seller should see that these requirements are met. Similar policies should apply to the provision of services.

17. Governments should encourage fair and effective competition in order to provide consumers with the greatest range of choice among products and services at the lowest cost.

18. Governments should, where appropriate, see to it that manufacturers and/or retailers ensure adequate availability of reliable after-sales service and spare parts.

/...

. Consumers should be protected from such contractual abuses as one-sided standard contracts, exclusion of essential rights in contracts, and unconscionable conditions of credit by sellers.

20. Promotional marketing and sales practices should be guided by the principle of fair treatment of consumers and should meet legal requirements. This requires the provision of the information necessary to enable consumers to take informed and independent decisions, as well as measures to ensure that the information provided is accurate.

21. Governments should encourage all concerned to participate in the free flow of accurate information on all aspects of consumer products.

22. Governments should, within their own national context, encourage the formulation and implementation by business, in co-operation with consumer organizations, of codes of marketing and other business practices to ensure ad iate consumer protection. Voluntary agreements may also be established jointly by business, consumer organizations and other interested parties. These codes should receive adequate publicity.

23. Governments should regularly review legislation pertaining to weights and measures and assess the adequacy of the machinery for its enforcement.

C. Standards for the safety and quality of consumer goods and services

24. Governments should, as appropriate, formulate or promote the elaboration and implementation of standards, voluntary and other, at the national and international levels for the safety and quality of goods and services and give them appropriate publicity. National standards and regulations for product safety and quality should be reviewed from time to time, in order to ensure that they conform, where possible, to generally accepted international standards.

25. Where a standard lower than the generally accepted international standard is be ; applied because of local economic conditions, every effort should be made to raise that standard as soon as possible.

26. Governments should encourage and ensure the availability of facilities to test and certify the safety, quality and performance of essential consumer goods and services.

D. Distribution facilities for essential consumer goods and services

27. Governments should, where appropriate, consider:

(a) Adopting or maintaining policies to ensure the efficient distribution of goods and services to consumers; where appropriate, specific policies should be considered to ensure the distribution of essential goods and services where this

distribution is endangered, as could be the case particularly in rural areas. Such policies could include assistance for the creation of adequate storage and retail facilities in rural centres, incentives for consumer self-help and better control of the conditions under which essential goods and services are provided in rural areas;

(b) Encouraging the establishment of consumer co-operatives and related trading activities, as well as information about them, especially in rural areas.

E. Measures enabling consumers to obtain redress

28. Governments should establish or maintain legal and/or administrative measures to enable consumers or, as appropriate, relevant organizations to obtain redress through formal or informal procedures that are expeditious, fair, inexpensive and accessible. Such procedures should take particular account of the needs of low-income consumers.

29. Governments should encourage all enterprises to resolve consumer disputes in a fair, expeditious and informal manner, and to establish voluntary mechanisms, including advisory services and informal complaints procedures, which can provide assistance to consumers.

30. Information on available redress and other dispute-resolving procedures should be made available to consumers.

F. Education and information programmes

31. Governments should develop or encourage the development of general consumer education and information programmes, bearing in mind the cultural traditions of the people concerned. The aim of such programmes should be to enable people to act as discriminating consumers, capable of making an informed choice of goods and services, and conscious of their rights and responsibilities. In developing such programmes, special attention should be given to the needs of disadvantaged consumers, in both rural and urban areas, including low-income consumers and those with low or non-existent literacy levels.

32. Consumer education should, where appropriate, become an integral part of the basic curriculum of the educational system, preferably as a component of existing subjects.

33. Consumer education and information programmes should cover such important aspects of consumer protection as the following:

(a) Health, nutrition, prevention of food-borne diseases and food adulteration;

(b) Product hazards;

(c) Product labelling;

(d) Relevant legislation, how to obtain redress, and agencies and organizations for consumer protection;

(e) Information on weights and measures, prices, quality, credit conditions and availability of basic necessities; and

(f) As appropriate, pollution and environment.

34. Governments should encourage consumer organizations and other interested groups, including the media, to undertake education and information programmes, particularly for the benefit of low-income consumer groups in rural and urban areas.

35. Business should, where appropriate, undertake or participate in factual and relevant consumer education and information programmes.

36. Bearing in mind the need to reach rural consumers and illiterate consumers, Governments should, as appropriate, develop or encourage the development of consumer information programmes in the mass media.

37. Governments should organize or encourage training programmes for educators, mass media professionals and consumer advisers, to enable them to participate in carrying out consumer information and education programmes.

G. Measures relating to specific areas

38. In advancing consumer interests, particularly in developing countries, Governments should, where appropriate, give priority to areas of essential concern for the health of the consumer, such as food, water and pharmaceuticals. Policies should be adopted or maintained for product quality control, adequate and secure distribution facilities, standardized international labelling and information, as well as education and research programmes in these areas. Government guidelines in regard to specific areas should be developed in the context of the provisions of this document.

39. Food. When formulating national policies and plans with regard to food, Governments should take into account the need of all consumers for food security and should support and, as far as possible, adopt standards from the Food and Agriculture Organization of the United Nations and the World Health Organization Codex Alimentarius or, in their absence, other generally accepted international food standards. Governments should maintain, develop or improve food safety measures, including, inter alia, safety criteria, food standards and dietary requirements and effective monitoring, inspection and evaluation mechanisms.

40. Water. Governments should, within the goals and targets set for the International Drinking Water Supply and Sanitation Decade, formulate, maintain or strengthen national policies to improve the supply, distribution and quality of water for drinking. Due regard should be paid to the choice of appropriate levels of service, quality and technology, the need for education programmes and the importance of community participation.

41. Pharmaceuticals. Governments should develop or maintain adequate standards, provisions and appropriate regulatory systems for ensuring the quality and appropriate use of pharmaceuticals through integrated national drug policies which could address, inter alia, procurement, distribution, production, licensing arrangements, registration systems and the availability of reliable information on pharmaceuticals. In so doing, Governments should take special account of the work and recommendations of the World Health Organization on pharmaceuticals. For relevant products, the use of that organization's Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce and other international information systems on pharmaceuticals should be encouraged. Measures should also be taken, as appropriate, to promote the use of international non-proprietary names (INNs) for drugs, drawing on the work done by the World Health Organization.

... In addition to the priority areas indicated above, Governments should adopt appropriate measures in other areas, such as pesticides and chemicals in regard, where relevant, to their use, production and storage, taking into account such relevant health and environmental information as Governments may require producers to provide and include in the labelling of products.

IV. International co-operation

43. Governments should, especially in a regional or subregional context:

(a) Develop, review, maintain or strengthen, as appropriate, mechanisms for the exchange of information on national policies and measures in the field of consumer protection;

(b) Co-operate or encourage co-operation in the implementation of consumer protection policies to achieve greater results within existing resources. Examples of such co-operation could be collaboration in the setting up or joint use of testing facilities, common testing procedures, exchange of consumer information and education programmes, joint training programmes and joint elaboration of regulations;

(c) Co-operate to improve the conditions under which essential goods are offered to consumers, giving due regard to both price and quality. Such co-operation could include joint procurement of essential goods, exchange of information on different procurement possibilities and agreements on regional product specifications.

44. Governments should develop or strengthen information links regarding products which have been banned, withdrawn or severely restricted in order to enable other importing countries to protect themselves adequately against the harmful effects of such products.

45. Governments should work to ensure that the quality of products, and information relating to such products, does not vary from country to country in a way that would have detrimental effects on consumers.

46. Governments should work to ensure that policies and measures for consumer protection are implemented with due regard to their not becoming barriers to international trade, and that they are consistent with international trade obligations.

Medical Codes of Ethics

The Hippocratic Oath

Little is known about the life of Hippocrates, a Greek physician born about 460 B.C. We know that he was a widely sought, well-known, and influential healer who is said to have lived 85, 90, 104, or 109 years. A collection of documents known as the *Hippocratic Writings* (largely written from the fifth to the fourth century, B.C.) is believed to represent the remains of the Hippocratic school of medicine. Some of the works in this collection are credited to Hippocrates. The oath reprinted here, however, is believed to have been written by a philosophical sect known as the Pythagoreans in the latter part of the fourth century, B.C.

For the Middle Ages and later centuries, the Hippocratic Oath embodied the highest aspirations of the physician. It sets forth two sets of duties: (1) duties to the patient and (2) duties to the other members of the guild (profession) of medicine. In regard to the patient, it includes a set of absolute prohibitions (e.g., against abortion and euthanasia) as well as a statement of the physician's obligation to help and not to harm the patient.

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

THE GENEVA CONVENTION CODE OF MEDICAL ETHICS

Adopted by the World Medical Association in 1949.

I solemnly pledge myself to consecrate my life to the service of humanity;
I will give to my teachers the respect and gratitude which is their due;
I will practice my profession with conscience and dignity;
The health of my patient will be my first consideration;
I will respect the secrets which are confided in me;
I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;
My colleagues will be my brothers;
I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
I will maintain the utmost respect for human life from the time of conception; even under threat. I will not use my medical knowledge contrary to the laws of humanity.
I make these promises solemnly, freely and upon my honour.

CODE FOR NURSES

At the meeting of the Grand Council of the International Council of Nurses (ICN) in Sao Paulo, Brazil, July 1953, an international code of ethics for nurses was first adopted. The Grand Council subsequently revised the Code at its meeting in Frankfurt, Germany, June 1965.

The Code for Nurses, as printed here, was produced by the Professional Services Committee and adopted by the ICN

WORLD MEDICAL ASSOCIATION

Declaration of Helsinki

Recommendations guiding medical doctors in biomedical research involving human subjects.

Adopted by the 18th World Medical Assembly, Helsinki, Finland, 1964, and revised by the 29th World Medical Assembly, Tokyo, Japan, October 1975.

Introduction

It is the mission of the medical doctor to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfilment of this mission.

The Declaration of Geneva of The World Medical Association binds the doctor with the words. "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest."

The purpose of biomedical research involving human subjects must be to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease.

In current medical practice most diagnostic, therapeutic or prophylactic procedures involve hazards. This applies *a fortiori* to biomedical research.

Medical progress is based on research which ultimately must rest in part on experimentation involving human subjects.

In the field of biomedical research a fundamental distinction must be recognized between medical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research, the essential object of which is purely scientific and without direct diagnostic or therapeutic value to the person subjected to the research.

Special caution must be exercised in the conduct of research which may affect the environment, and the welfare of animals used for research must be respected.

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, The World Medical Association has prepared the following recommendations as a guide to every doctor in biomedical research involving human subjects. They should be kept under review in the future. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.

I. Basic principles

1. Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific literature.

2. The design and performance of each experimental procedure involving human subjects should be clearly formulated

in a experimental protocol which should be transmitted to a specially appointed independent committee for consideration, comment and guidance.

3. Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of research, even though the subject has given his or her consent.

4. Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

5. Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interests of the subject must always prevail over the interests of science and society.

6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject's physical and mental integrity and on the personality of the subject.

7. Doctors should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Doctors should cease any investigation if the hazards are found to outweigh the potential benefits.

8. In publication of the results of his or her research, the doctor is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication.

9. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that

he or she is free to withdraw his or her consent to participation at any time. The doctor should then obtain the subject's freely-given informed consent, preferably in writing.

10. When obtaining informed consent for the research project the doctor should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a doctor who is not engaged in the investigation and who is completely independent of this official relationship.

11. In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation.

12. The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present Declaration are complied with.

II. Medical research combined with professional care (clinical research)

1. In the treatment of the sick person, the doctor must be free to use a new diagnostic and therapeutic measure, if in his or her judgement it offers hope of saving life, reestablishing health or alleviating suffering.

2. The potential benefits, hazards and discomfort of a new method should be weighed against the advantages of the best current diagnostic and therapeutic methods.

3. In any medical study, every patient—including those of a control group, if any—should be assured of the best proven diagnostic and therapeutic method.

4. The refusal of the patient to participate in a study must never interfere with the doctor-patient relationship.

5. If the doctor considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in the experimental protocol for transmission to the independent committee (1, 2).

6. The doctor can combine medical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value for the patient.

III. Non-therapeutic biomedical research involving human subjects (non-clinical biomedical research)

1. In the purely scientific application of medical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom biomedical research is being carried out.

2. The subjects should be volunteers—either healthy persons or patients for whom the experimental design is not related to the patient's illness.

3. The investigator or the investigating team should discontinue the research if in his/her or their judgement it may, if continued, be harmful to the individual.

4. In research on man, the interest of science and society should never take precedence over considerations related to the well-being of the subject.

APPENDIX F

REPORT

OF THE REGISTRAR

OF

MEDICAL SCHEMES

TO THE

CENTRAL COUNCIL FOR MEDICAL SCHEMES

For the year ending

31 DECEMBER 1990

Registrar of Medical Schemes
Private Bag X828
PRETORIA
0001

Tel: (012) 324-3631

STATISTIEK VAN LEDE SOOS OP: 31 DESEMBER 1989 BYLAE
MEMBERSHIP STATISTICS AS AT: 31 DECEMBER 1989 ANNEXURE 1

	Hulpskemas Aid Schemes	Bystandskemas Benefit Schemes	Vrygestelde Skemas Exempted Schemes	TOTAAL TOTAL
1. Lede/Members				
Asiers/Asians	71,689	2,002	57,794	131,485
Blankes/Whites	1,160,025	125,976	81,696	1,367,697
Kleurlinge/Coloureds	169,944	44,676	148,021	362,641
Swartes/Blacks	325,521	45,854	86,787	458,162
TOTAAL/TOTAL (A)	1,727,179	218,508	374,298	2,319,985
2. Afhanklikes/Dependants				
Asiers/Asians	150,578	3,337	28,144	182,059
Blankes/Whites	1,738,288	222,843	123,592	2,084,723
Kleurlinge/Coloureds	340,297	74,655	157,204	572,156
Swartes/Blacks	794,744	61,421	60,224	916,389
TOTAAL/TOTAL (B)	3,023,907	362,256	369,164	3,755,327
3. Voordeeltrekkers Beneficiaries				
Asiers/Asians	222,267	5,339	85,938	313,544
Blankes/Whites	2,898,313	348,819	205,288	3,452,420
Kleurlinge/Coloureds	510,241	119,331	305,225	934,797
Swartes/Blacks	1,120,265	107,275	147,011	1,374,551
TOTAAL/TOTAL (A+B)	4,751,086	580,764	743,462	6,075,312

LEDESTATISTIEK - ALLE SKEMAS - 31-12-1989
MEMBERSHIP STATISTICS - ALL SCHEMES - 31-12-1989

BYLAE
ANNEXURE 2

	Gewone Ordinary	Pensioenarisse Pensioners	Weduwees Widows	TOTAAL TOTAL
1. Lede/Members				
Asiers/Asians	129,316	1,268	901	131,485
Blankes/Whites	1,180,850	137,467	49,380	1,367,697
Kleurlinge/Coloureds	353,376	6,824	2,441	362,641
Swartes/Blacks	454,492	2,825	845	458,162
TOTAAL/TOTAL (A)	2,118,034	148,384	53,567	2,319,985
2. Afhanklikes/Dependants				
Asiers/Asians	179,159	1,799	1,101	182,059
Blankes/Whites	1,961,726	107,704	15,293	2,084,723
Kleurlinge/Coloureds	562,153	7,640	2,363	572,156
Swartes/Blacks	907,902	6,598	1,889	916,389
TOTAAL/TOTAL (B)	3,610,940	123,741	20,646	3,755,327
3. Voordeeltrekkers **Beneficiaries**				
Asiers/Asians	308,475	3,067	2,002	313,544
Blankes/Whites	3,142,576	245,171	64,673	3,452,420
Kleurlinge/Coloureds	915,529	14,464	4,804	934,797
Swartes/Blacks	1,362,394	9,423	2,734	1,374,551
TOTAAL/TOTAL (A+B)	5,728,974	272,125	74,213	6,075,312

BYLAE
ANNEXURE 3

LEDESTATISTIEK : -
MEMBERSHIP STATISTICS: -

ALLE SKEMAS - 31 DESEMBER 1989
ALL SCHEMES - 31 DECEMBER 1989

BEVOLKINGSGROEP : POPULATION GROUP :	VOORDEELTREKKERS : BENEFICIARIES :	* BEVOLKING : POPULATION :	% DEKKING COVER
Swart/Black	1,374,551	21,105,000	6.5
Kleurling/Coloured	934,797	3,168,000	29.5
Asier/Asian	313,544	941,000	33.3
Blank/White	3,452,420	4,979,000	69.3
TOTAAL/TOTAL	6,075,312	30,193,000	20.1

* Middeljaarraming soos op 30 Junie 1989 soos verskaf deur Sentrale Statistiekdiens.
Midyear estimated figures as at 30 Junie 1989 furnished by Central Statistical Services.

FINANSIELE STATISTIEK: 31 DESEMBER 1989 BYLAE
FINANCIAL STATISTICS: 31 DECEMBER 1989 ANNEXURE 4

1. Inkomste/Income

	Ledegeld / Membership Fees	Ander Inkomste / Other Income	TOTAAL / TOTAL
	R	R	R
Mediese Hulpskemas / Medical Aid Schemes	3,657,635,708	237,544,283	3,895,179,991
Mediese Bystandskemas / Medical Benefit Schemes	360,780,931	24,627,664	385,408,595
Vrygestelde Skemas / Exempted Schemes	245,675,385	16,190,811	261,866,196
TOTAAL/TOTAL	4,264,092,024	278,362,758	4,542,454,782

2. Administrasiekoste/Administration Costs

Hulpskemas / Aid Schemes	Bystandskemas / Benefit Schemes	Vrygestelde Skemas / Exempted Schemes
R	R	R
207,027,336	19,953,039	22,596,700

TOTAAL/TOTAL	249,577,075

FINANSIELE STATISTIEK: (VERVOLG)
FINANCIAL STATISTICS: (CONTD)

BYLAE 5
ANNEXURE

VOORDELE AAN LEDE / BENEFITS TO MEMBERS: 1989-12-31

	Mediese Hulpskemas Medical Aid Schemes		Mediese Bystandskemas Medical Benefit Schemes		Vrygestelde Skemas Exempted Schemes		TOTAAL TOTAL	
	R	%	R	%	R	%	R	%
Algemene Praktisyns General Practitioners	547,718,380	16.3	50,638,052	15.8	35,256,581	16.9	633,613,013	16.3
Mediese Spesialiste Medical Specialists	606,800,240	18.1	41,963,167	13.1	34,120,876	16.4	682,884,283	17.6
Tandartse (insluitend Spesialiste) Dentists (including Specialists)	379,272,298	11.3	24,180,097	7.5	17,975,981	8.6	421,428,376	10.8
Hospitalisasie - Provinsiaal/Provincial	161,074,358	4.8	30,726,614	9.6	13,453,627	6.5	205,254,599	5.3
Hospitalisation - Privaat/Private	567,983,737	16.9	43,346,680	13.5	22,099,785	10.6	633,430,202	16.3
TOTAAL/TOTAL	729,058,095	21.7	74,073,294	23.0	35,553,412	17.1	838,684,801	21.6
Medisyne Medicine	851,397,542	25.4	107,317,218	33.4	70,616,250	33.9	1,029,331,010	26.5
Ex-Gratia-betalings/Payments	8,689,105	0.3	180,949	0.1	2,782,969	1.3	11,653,023	0.3
Ander Voordele Other Benefits	232,432,078	6.9	23,152,633	7.2	11,876,600	5.7	267,461,311	6.9
TOTAAL/TOTAL	3,355,367,738	100	321,505,410	100	208,182,669	100	3,885,055,817	100

BATES EN LASTE - 31 DESEMBER 1989
ASSETS AND LIABILITIES - 31 DECEMBER 1989

BYLAE 6
ANNEXURE

BATES/ASSETS:

	SOORT SKEMA / TYPE OF SCHEME			
	HULP/AID	BYSTAND/BENEFIT	VRYGESTELDE/EXEMPTED	TOTAAL/TOTAL
	R	R	R	R
Onroerende Eiendom/Immovable Property	19,326,500	12,210,159	577,901	32,114,560
Meubels en Uitrusting/Furniture & Equipment	20,402,903	9,620,875	199,767	30,223,545
Beleggings/Investments	1,057,587,681	90,869,942	93,920,491	1,242,378,114
Debiteure en Vooruitbetalings/Debtors & Prepayments	244,892,864	30,517,383	17,007,987	292,418,234
Kontant en Banksaldo's/Cash and Bank Balances	205,918,455	10,578,634	8,462,511	224,959,600
Ander Bates/Other Assets	48,715,466	2,741,724	6,435,396	57,892,586
TOTAAL/TOTAL	1,596,843,869	156,538,717	126,604,053	1,879,986,639

LASTE/LIABILITIES

Krediteure vir Eise/Creditors for Claims	63,213,519	16,262,602	5,381,172	84,857,293
Bydraes Vooruit Ontvang/Contributions In Advance	76,232,217	1,419,029	698,593	78,349,839
Ander Krediteure/Other Creditors	187,854,056	13,582,107	6,118,391	207,554,554
Garansie Deposito's/Guarantee Deposits	2,430,128	0	0	2,430,128
Voorsiening vir eise nog nie ontvang/Provisions for claims not yet received	460,384,524	17,658,538	34,205,409	512,248,471
Ander Voorsienings/Other Provisions	30,495,661	6,309,146	1,957,525	38,762,332
TOTAAL/TOTAL	820,610,105	55,231,422	48,361,090	924,202,617
NETTO BATES/NETT ASSETS	776,233,764	101,307,295	78,242,963	955,784,022

		1980	% of group	1981	% of group	1982	% of group	1983	% of group	1984	% of group
3.	VOORDEELTREKKERS/BENEFICIARIES										
3.1	Asiers / Asians	202,104	4.7	212,122	4.4	229,394	4.7	234,052	4.6	235,689	4.5
3.2	Blankes / Whites	3,211,542	74.2	3,535,509	72.9	3,473,742	71.5	3,541,846	70.1	3,461,642	66.5
3.3	Kleurlinge / Coloureds	575,076	13.3	634,195	13.1	672,833	13.8	655,053	13.0	768,828	14.8
3.4	Swartes / Blacks	340,534	7.9	468,140	9.7	484,898	10.0	623,890	12.3	740,320	14.2
3.5	**TOTAAL / TOTAL**	**4,329,256**	**100**	**4,849,966**	**100**	**4,860,867**	**100**	**5,054,841**	**100**	**5,206,479**	**100**
3.6	% van Bevolking / % of Population	17.3		19.0		18.6		19.0		19.1	

		1985	% of group	1986	% of group	1987	% of group	1988	% of group	1989	% of group
3.	VOORDEELTREKKERS/BENEFICIARIES										
3.1	Asiers / Asians	249,893	4.7	262,217	4.9	275,096	5.0	313,797	5.4	313,544	5.2
3.2	Blankes / Whites	3,448,684	65.5	3,415,810	63.4	3,340,865	61.0	3,401,661	58.8	3,452,420	56.8
3.3	Kleurlinge / Coloureds	791,719	15.0	804,995	15.0	853,833	15.6	941,475	16.3	934,797	15.4
3.4	Swartes / Blacks	778,281	14.8	900,454	16.7	1,003,030	18.3	1,128,323	19.5	1,374,551	22.6
3.5	**TOTAAL / TOTAL**	**5,268,577**	**100**	**5,383,476**	**100**	**5,472,824**	**100**	**5,785,256**	**100**	**6,075,312**	**100**
3.6	% van Bevolking / % of Population	18.9		18.9		18.9		19.5		20.1	

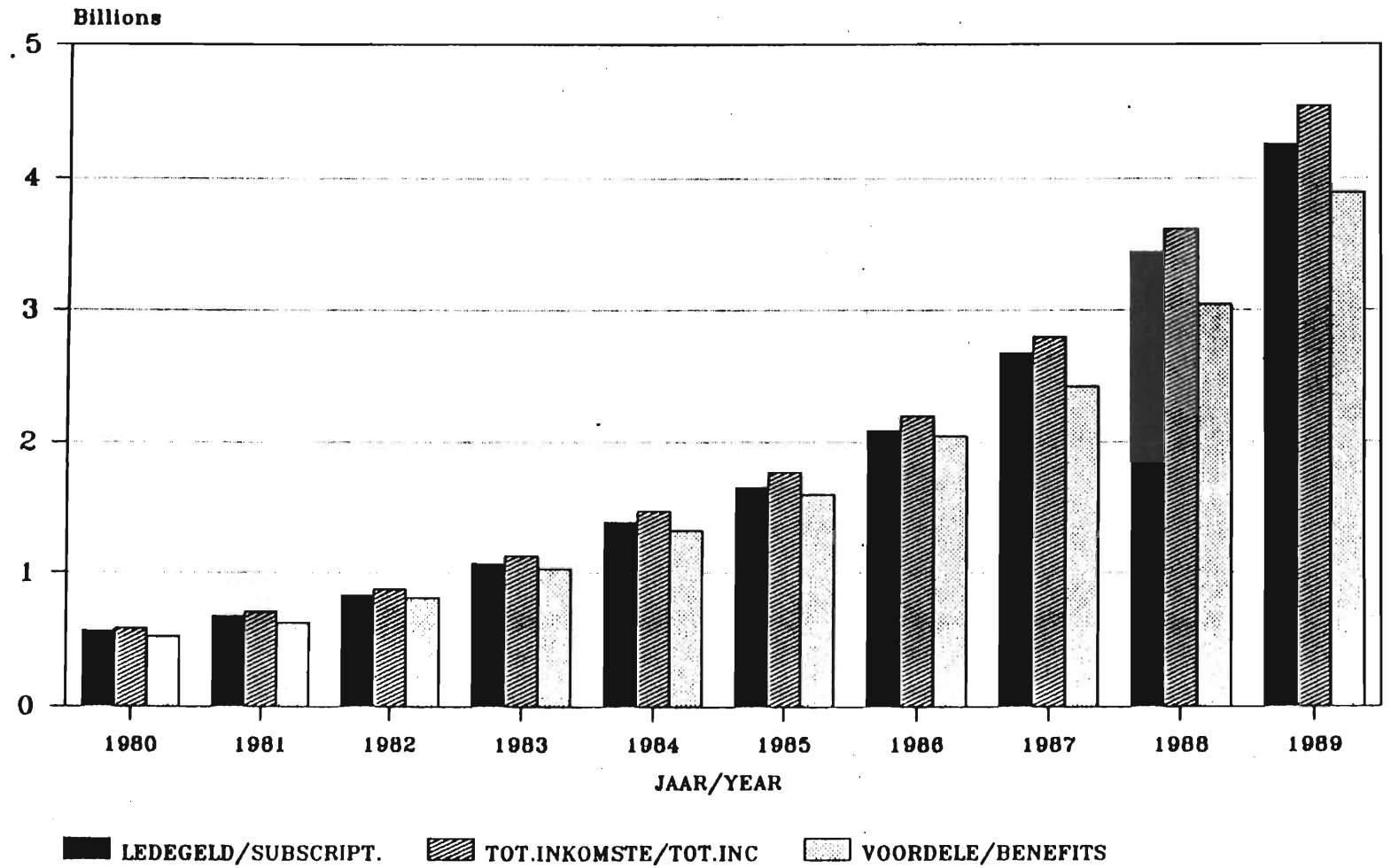
		1980	%	1981	%	1982	%	1983	%	1984	%
4.	AANTAL MEDIESE SKEMAS / NUMBER OF MEDICAL SCHEMES										
* 4.1	Hulpskemas / Aid Schemes	214	74	198	72	202	74	206	76	192	75
* 4.2	Bystandskemas / Benefit Schemes	28	10	29	11	23	8	22	8	20	8
4.3	Vrygestelde Skemas/Exempted Schemes	47	16	48	17	47	17	44	16	44	17
4.4	**TOTAAL / TOTAL**	**289**	**100**	**275**	**100**	**272**	**100**	**272**	**100**	**256**	**100**

		1985	%	1986	%	1987	%	1988	%	1989	%
4.	AANTAL MEDIESE SKEMAS / NUMBER OF MEDICAL SCHEMES										
* 4.1	Hulpskemas / Aid Schemes	191	76	192	76	188	76	188	75	189	76
* 4.2	Bystandskemas / Benefit Schemes	18	7	18	7	18	7	19	8	18	7
4.3	Vrygestelde Skemas/Exempted Schemes	43	17	43	17	43	17	43	17	43	17
4.4	**TOTAAL / TOTAL**	**252**	**100**	**253**	**100**	**249**	**100**	**250**	**100**	**250**	**100**

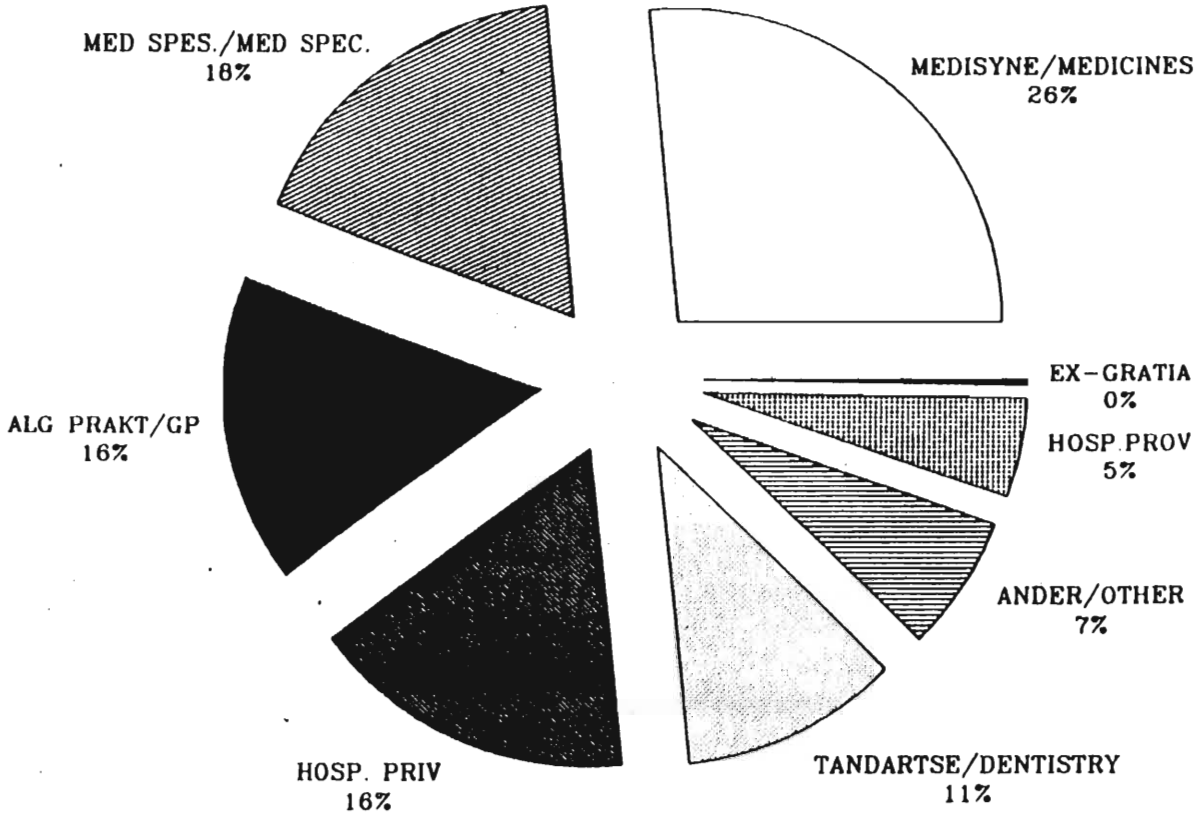
ERRATUM: JAARVERSLAG: REGISTRATEUR VAN MEDIESE SKEMAS VIR 1990

ANNUAL REPORT: REGISTRAR OF MEDICAL SCHEMES FOR 1990

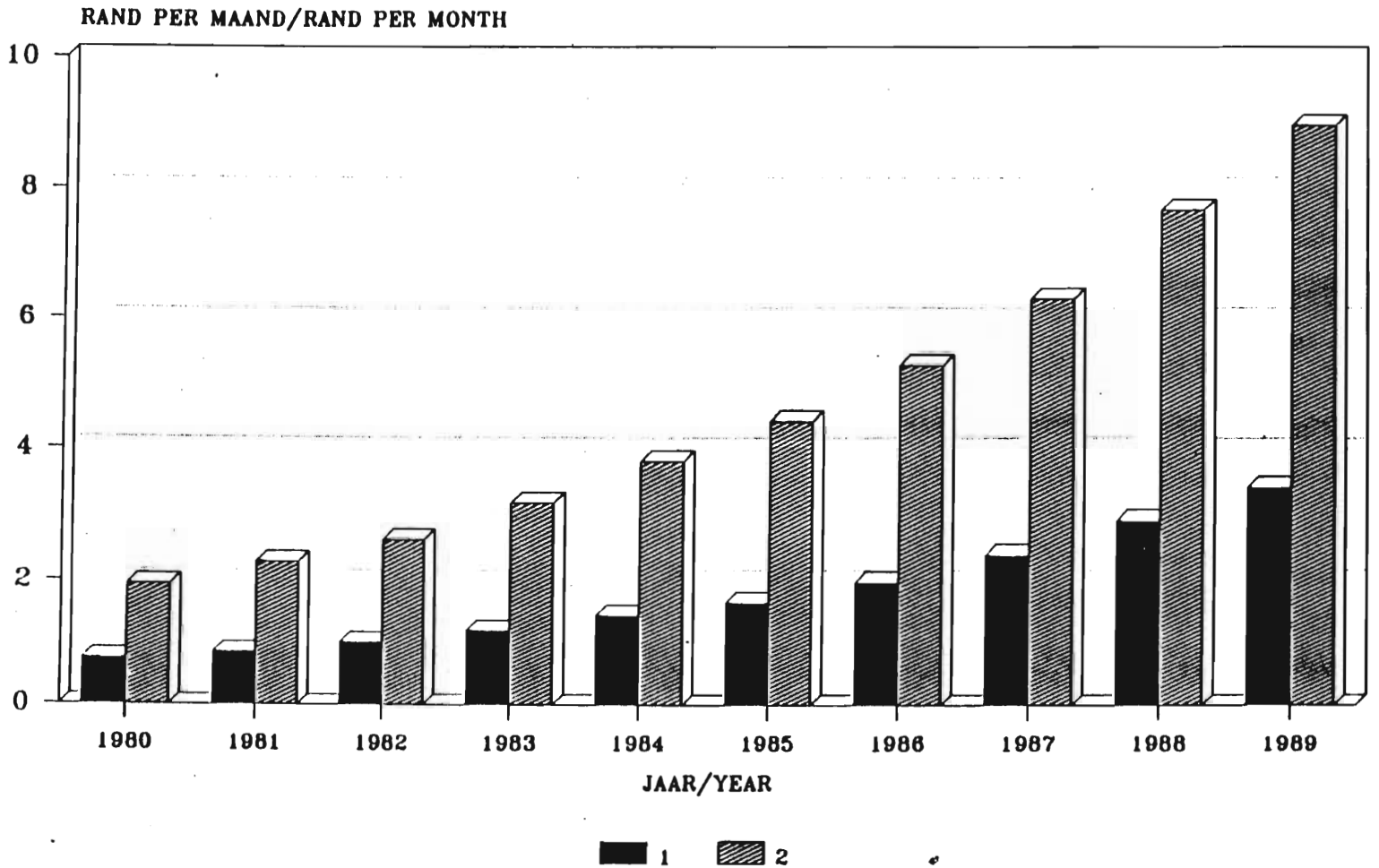
MEDIESE SKEMAS / MEDICAL SCHEMES
INKOMSTE – VOORDELE BETAAL
INCOME – BENEFITS PAID



VOORDELE AAN LEDE: 1989
BENEFITS TO MEMBERS: 1989



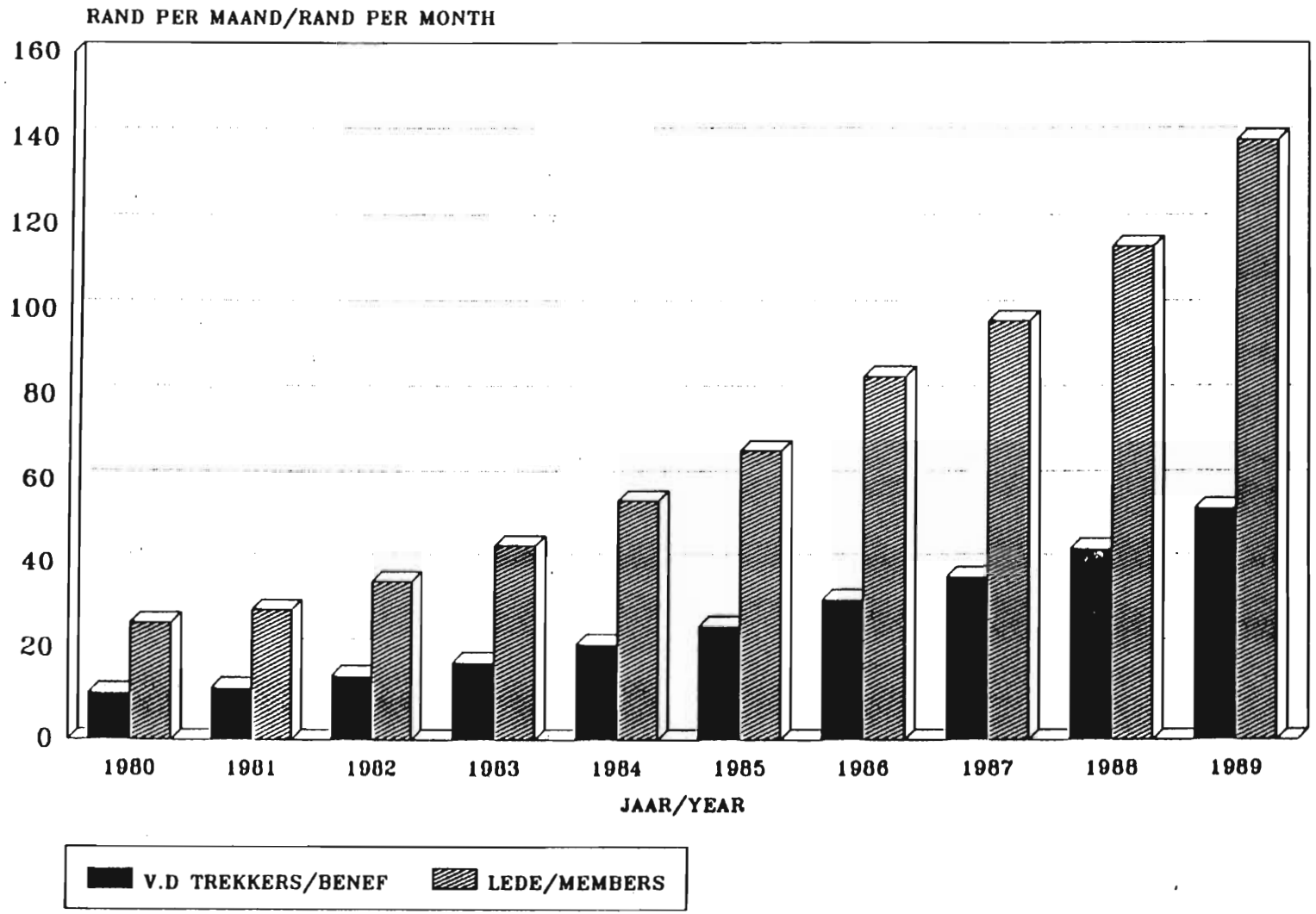
ADMINISTRASIEKOSTE : MEDIESE SKEMAS
ADMINISTRATION COSTS : MEDICAL SCHEMES



1=GEMIDDELD/VOORDEELTREKKER/MAAND
AVERAGE/BENEFICIARY/MONTH
2=GEM/LID/MAAND AV/MEMBER/MONTH

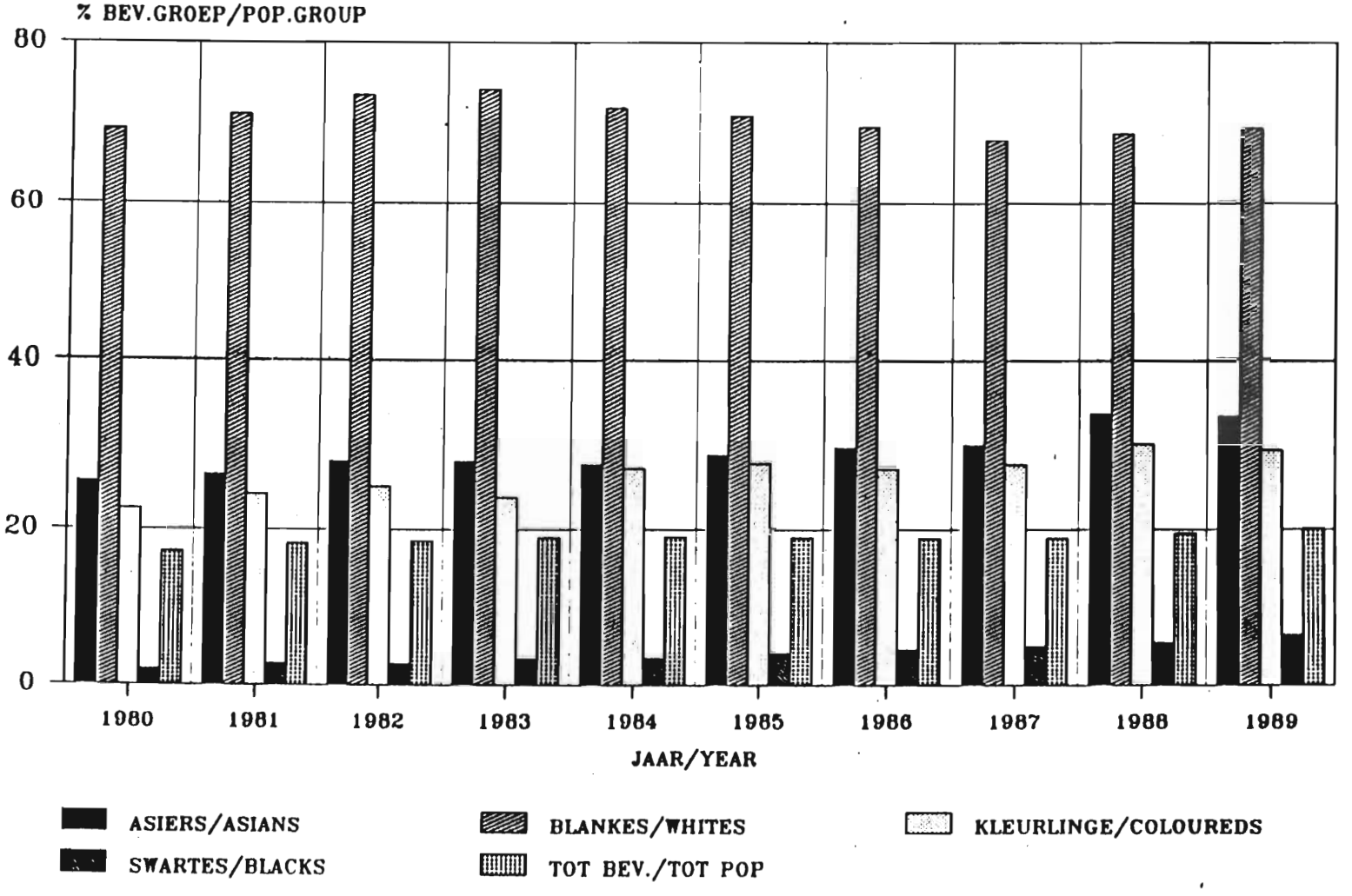
BYLAE
ANNEXURE 12

VOORDELE P/MAAND-LEDE + VOORDEELTREKKERS
BENEFITS P/MONTH-MEMBERS + BENEFICIARIES



BYLAE
ANNEXURE 13

VOORDEELTREKKERS: % DEKKING VAN GROEP
BENEFICIARIES: % OF GROUP COVERED



APPENDIX G

QUESTIONNAIRE

1a Do you/your family receive medical treatment from:-

Private doctors/specialists/clinics
Government subsidized hospitals/clinics/
Both

b If you receive medical treatment from both private doctors and government subsidized institutions, which one do you use more often

Private doctors	Govt. subsidized Facilities

2 Do you prefer receiving:

	YES	NO
Private medical treatment; Treatment from government subsidized institutions		

3 Do you prefer the:

	YES	NO
Existing system of medical care delivery in South Africa		
or the establishment of a National Health Service		

N.B. A national Health Service is a system whereby every citizen receives free medical care for any illness from any doctor hospital that he/she chooses. It is funded by the Government, and doctors receive a salary from the Government rather than receive fees from patients.

4 If you do use private medical services why do you do so.

Because you belong to a medical aid scheme which pays a portion of the cost ----
You prefer not to use the state subsidized centres even though you pay for medical care personally ----

The facilities are better ----
The treatment is better than state subsidized institutions ----

Other: Specify ----

PLEASE SPECIFY TYPE OF SPECIALIST IN THE COLUMNS BELOW IN ALL RELEVANT QUESTIONS.

5 If you are a user of private medical care are you satisfied with the services rendered by

		Not Satisfied	Fairly Satisfied	Very Satisfied
Your family doctor/GP	1			
Specialists	2			
Private Hospitals	3			

6 Is there anything at all that you maybe dissatisfied with regarding private medical care. Tick as many as applicable.

	Family Doctor	Specialist	Hospital
Untidy, gloomy waiting rooms			
Long waiting periods			
Unpleasant staff			
Wrong diagnosis			
Overcharging			
Ill mannered doctor			
Treated with no respect/ compassion			
No assistance in emergencies or at night			
Submits accounts for telephone consultation			
Answers non urgent or business telephone calls while attending to you			
The doctors hours of consultation are too limited			
Does not make house-calls in emergencies			
Other: Specify			

7 Is there any thing that you are particularly satisfied with in respect of PRIVATE MEDICAL CARE

	Doctor	Specialist	Hospital
Kind and caring attitude of doctor			
Kind and caring attitude of staff			
Available after hours			
Proper explanation of illness			
Clean and pleasant waiting rooms			
Answers telephone queries			
Other: Specify			

8 Press reports often highlight shortcomings in public services. If you are a user of private medical facilities, would you be prepared to use state subsidized facilities if condititons were to materially improve at these centres.

No, still prefer private medical care
No, I belong to a medical aid scheme
Yes
Other: Specify

9 If you are a user of state subsidized institutions, why do you use them?

Not a member of medical aid scheme
Not enough money to pay for private medical care
Better equipment
Other: Specify

10a If you have used state subsidized facilities and you have been dissatisfied therewith please indicate the reasons for your dissatisfaction. Tick as many as applicable.

Lack of respect/compassion of doctors ----

Lack of respect/compassion of other staff ----

Untidy and unpleasant waiting rooms ----

Long waiting periods ----

Lack of sufficient treatment facilities ----

Other: Specify ----

b If you have been satisfied please tick the reasons for your satisfaction.

Low cost of treatment and medicines ----

Caring doctors ----

Caring staff ----

Easily accessible at all times ----

Greater value for money ----

Other: Specify ----

11	Do you believe that private doctors:	Family Doctor	Specify Specialist
	are mainly in the profession to help the population with their health problems	----------	
	to offer better services than state institutions	----------	
	to make as much money as possible	----------	
	other: specify	----------	

		YES	NO
12a	Are you a member of a Medical Aid Scheme	----------	
b	Do you have a Medical Insurance Policy	----------	
c	Do you prefer to be a member of a Medical Aid Scheme	----------	

13 Would you visit the doctor as often as you presently do if you were not a member of a Medical Aid Scheme

YES	NO	DON'T KNOW

(TO BE ANSWERED BY MEDICAL AID MEMBERS ONLY)

14 Do you think that Medical Aid Schemes:

	YES	NO	D/K
Are necessary in order to receive private Medical treatment			
Result in higher costs of medical care			
Are being abused by doctors			
Are being abused by patients			
Provide adequate financial cover			
Act as a representative organisation with regard to medical problems			
Other: specify			

15 Would you like to see the establishment of an independent Patient's Association which may advise and represent you with regard to problems that you may experience with some hospitals or some doctors

YES	NO	DON'T KNOW

16a Do you consider the cost of private medical care to be

Too high
Reasonable/fair
Low

b Does your doctor give you a discount if you pay in cash immediately after the consultation

YES	NO	D/KNOW

17 Do you think that doctor's fees should be based on:

	YES	NO	D/KNOW
Time spent with patients			
Different types of diagnostic equipment used			
The nature of the treatment			
All of the above			
Other: specify			

18 Would you prefer to know something about your doctor/specialist before hand.

YES	NO

Family doctor
Specialist

19 Did you obtain any information at all about your doctor before consulting with him

	NO	VERY LITTLE	YES SUFFICIENT
Doctor			
Specialist			

20 Where do you get your information about:

	family doctor	specialist
Family doctor		
Other doctors		
From friends		
From family		
No source of information:		
Other specify		

21 If you have more than one family doctor, please indicate why?
N/A
Different members of the family prefer different doctors
When one is busy, you go to the other
Other: specify

22 Do you feel you should be free to consult a specialist without a referral from a family doctor?

No, since my family doctor knows best ----

Yes, especially when I know that the family doctor does not have the diagnostic tests and equipment ----

Yes, because it is a waste of time, just to sit and wait for the doctor's approval ----

Yes, because your family doctor is going to charge you for a consultation just to agree to send you to a specialist that you suggest. ----

23 When you are dissatisfied with your doctor's treatment and/or attitude to you or your family, do you complain about it to:

	family doctor	Specify type of specialist
Not applicable		
The doctor himself		
Your friends		
Your family		
Other doctors		
The SAMDC		
Your attorney		
Other: specify		

24 Do you continue to consult with a doctor with whom you are dissatisfied

	family doctor	specialist
Not applicable		
Sometimes		
Always		

25 Do you discourage friends/relatives from going to a doctor with whom you are dissatisfied.

	family doctor	specialist
Never had the experience, but would do		
Sometimes		
Always		
Never		

	YES	NO	D/K
26 Do they follow your advice?			

27 Do you believe that you/your family were a victim/victims of medical negligence or malpractice.

YES	NO	D/K

28a Are you aware that you may complain to the South African Medical and Dental Council (SAMDC) about any problems with doctors. (The SAMDC is an official body which exercises control over doctors)

YES	NO	D/K

b Do you believe that the SAMDC protects patients adequately through their disciplinary processes

YES	NO	DON'T KNOW MUCH ABOUT SAMDC

29 Have you ever complained to the SAMDC about any misdemeanours or malpractices.

YES	NO	NO REASON TO

30 If you have complained to the SAMDC: did you receive a response from the SAMDC?

Yes, it was a reasonable response
Yes, it was an unsatisfactory response
No response at all

31a Have you ever sued your doctor for malpractice/negligence?

YES	NO

b Have you considered suing your doctor for malpractice/negligence?

YES	NO

32a Was the outcome/result in your favour?

YES	NO	N/A

b Have you had difficulty in getting other doctors to assist you in your case

YES	NO	N/A

33 Do you prefer to know the name of the medicine or other treatment that you are receiving?

YES	NO

34 Why do you prefer to know the name of the medicine or treatment

To determine whether you are allergic to it
To know what precautions to take
To be able to tell other doctors/specialists about it should the need arise
To know whether you have the medication available at home before you buy the medicine
Other specify:

35 Do you believe that you should be told by the chemist/doctor/specialist of:

YES NO D/KNOW

i the possible adverse effects of the medicine that you/your family are taking.

ii the possible risks of surgery/treatment

36a Does your doctor/specialist/chemist furnish you with sufficient information about the medicines/treatment with regard to

	DOSAGE Dr/Spec/Chem	Adverse Effects Dr/Spect/Chem	Precautions Dr/Spec/Chem
sometimes			
always			
never			

b Does your doctor furnish you with sufficient information about the risks before he commences treatment or surgery?

	YES	NO	DON'T KNOW
Doctor			
Specialist:			specify

37 When an adverse reaction results after you take your medicine/treatment, do you report this to your

	SOMETIMES	ALWAYS	NEVER
doctor			
Specialist			
pharmacist			
has not occurred			

38 When you report to him what does he do

	family doctor	specialist	pharmacist
Not applicable			
Take back the medicine in exchange for another			
Take back the medicine and refunds you			
Asks you to continue using it but with certain pre-			

cautions which he didn't mention before ----------

Asks you to come in for a further consultation ----------

Other: specify

39 Do you believe you should be allowed to return medicines and be reimbursed for those that cause adverse reactions and for which you have to pay

YES	NO	DON'T KNOW

40 What costs should be reimbursed?

Costs of medicines only
Costs of medicines plus the cost of attending to the adverse reactions
Other: specify

41a Should medicines be accompanied by a sample to test for allergic reactions. Using the sample would mean that the medicine itself would not be tampered with or contaminated and could then be returned.

SOME SHOULD	ALL SHOULD	NO

b If your answer is NO, why not?

Costs of medication will increase
Possibility still exists that products will be tampered with
Other: specify

42 Do you think that doctors should be allowed to advertise their services with certain controls

Yes, you would have better knowledge about them
Yes, it would result in price competition
No it would result in confusion
No it would result in higher prices

43 What kinds of information should such an advertisement contain

Whether he is a dispensing doctor
What he is especially qualified for
His hours and days of consultation in different locations as well, if he has more than one surgery
His after hours policies
His fees
All of the above

Other: specify

44 Does your family doctor permit you to make appointments with him

YES NO

45 Would you prefer to make appointments to see your family doctor.

YES NO

46 Are you attended to punctually when you have made appointments with your

doctor	specialist
Sometimes	
Always	
No	

47 How long do you normally wait to be attended to:

doctor	specialist
less than 15 mins.	
15 - 30 mins.	
30 mins. - 1 hr.	
1 - 2 hrs	
more than 2 hrs.	

48a How do you feel about waiting?

Annoyed
Don't mind it
Afraid of contracting other diseases that others have
Other: specify

b Are you concerned about anything when you consult your doctor/specialist

	YES	NO
That he may not wash his hands after treating other patients		
That he may use needles that have been used		
That his equipment are not sterilized		
Other: specify		

49 Do you have difficulty in making an appointment with your specialist when you feel you are in urgent need of medical attention.

Sometimes	always	never

50 When you telephone your doctor/specialist are you able to speak to him?

	No	Sometimes	Always
doctor			
specialist			

51 What is the nature of your call

To elicit more information regarding your illness
Report allergic reaction of medicine/treatment
Directions for use of medicine
To find out about results of tests that doctor asked you to undergo
Other: specify

52 Do you think that the doctor's "busyness' is a justification for not answering or returning a call to a bona fide patient.

No	Sometimes	Always

53 Do you believe that your doctor unnecessarily:

	YES	NO
Sends you for tests		
Gives you too many medicines		
Asks you to undergo X rays, scans		
Asks you to have an induced labour		
Gives you an epidural without your request		
Other: specify		

PERSONAL DETAILS

54 Please indicate the highest level of education of

	yourself	husband	wife
Less than matric			
Matric			
Post-matric student			
Graduate			
Post matric diploma			
Post graduate			

55 Please indicate your race and your doctor's race.

	White	Black	Indian	Coloured	Other
your race					
family doctor's race					
specialist's race					

56 Please indicate your total household income per month. (i.e. husband's and wife's salary together)

- less than R1 500
- R1 500 - R4 500
- R4 500 - R7 500
- more than R7 500

	under 30	30-45	45-60	over 60
57 Please indicate the age of				
household head				
spouse				

58 Please indicate the number of people in your household.

0 - 2 ----

2 - 6 ----

6 - 10 ----

more than 10 ----

COPY

Dear Sir

re: MRS. _____

The attached letter has been referred to us by our client, Mrs.

The last paragraph of the letter speaks for itself and was read by all concerned with amazement and with little credit to the medical profession.

One talks generally of an attitude of Doctors who close ranks, but of course this is always denied by Doctors who emphatically say this doesn't happen.

It is our client's instruction to request this matter to be referred to the Medical Council and if they refuse to deal with the matter, then our client believes that morally it is correct for her to have the "incident" published as an article in a press report circulating throughout South Africa.

You are invited to give an explanation which will then be submitted to the Council or to the press as the case may be. By innuendo, Mr. and his dependants have been considered to be improper for radiological assessments by your practice and that is defamatory.

The answer remains yours.

Yours faithfully

_____

Per :

APPENDIX H

PASIËNT / PATIENT:- (w/o B P)

MED. FONDS / AID:-

VERWYS / REFERRED:-

DATUM / DATE:- 12/09/90

Dear Colleague

CHEST

A very slight rotation convexity of the mid lower dorsal spine to the right is present.
Slight endplate irregularity i.r.t single of the vertebrae is present with also early spondylotic lipping i.r.t the single of the mid upper dorsal vertebrae.

Minimal unfolding of the aortic arch is present.
The latter is still within normal limits with the mediastinum and c v s otherwise having a normal appearance.

Increased lung markings are present in both lung fields slightly more on the right than the left with also single hilar bronchi with wall thickening,
This is regarded as due to a light slightly chronic bronchial infection.
The patients clinical picture must just be corrolated.
The possibility of very slight airflow impairment cannot be completely excluded due to the slight translucency of the left lung.
The view is done in slight rotation and this might have been the cause for the beforementioned.

Otherwise underlying pulmonary pathology is not noted.

Single basal pleuritic adhesions are present more on the right than the left due to previous pleurisy and your findings regarding possibile present light pleurisy must just be taken into consideration.

Otherwise within normal limts.

**As there is another radiological service in Newcastle, no further x-ray examination will be undertaken by this practice for Mr and his dependants.
Services will only be rendered in the case of a possible emergency.**

Regards

/vs