GRADUATION ADDRESS

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On receiving the honorary degree of LLD

Mr Vice-Chancellor Prof. Charlton, Deputy Vice-Chancellor Prof Selischop, Chairman of Council Mr. Anderson, Dean of the Faculty of Medicine Prof Hart, Fellow Academic Colleagues, Graduands and their Families and Friends, Ladies and Gentlemen:

I thank the University for the high honour it has bestowed on me. I thank you also for inviting me to address this distinguished assembly.

To begin with, let one congratulate the graduands who have successfully overcome the trials and tribulations of six or more years of study and who now have the title of doctor before their names and the magical letters MB BCh (Wits) after their names. Congratulations also to your families and friends who have travelled the long journey with you and can now breathe freely again and share in your triumph and your rejoicing.

But ladies and gentlemen and new colleagues this victory is only the end of the beginning. The real battle which now faces the graduands, this University and indeed all of society is far more difficult and challenging.

I wish to speak and to speak plainly about the health or rather the bad health of our nation of first and third world peoples. As a good doctor I shall make the diagnosis from which will follow the solutions.

We are all aware that the burden of sickness in this country is very heavy. The reasons are simple and they are mainly three. In order of importance they are:

1. bad environment
2. bad lifestyle and
3. bad medical services.

All three affect both our first and third world peoples but in different ways and to different degrees. Thus the 20% of South Africans who are first world citizens suffer much from 20th century epidemics such as heart disease, stroke, cancer, obesity, high blood pressure, and diabetes all of which are largely related to bad lifestyle - namely smoking, excessive drinking, bad eating, and sloth or physical inactivity. In the 80% of our citizens who are of the third world, sickness is more complex and far worse. They still suffer from the ancient plagues of pestilence and malnutrition compounded by the recent explosion of AIDS. But added to these increasingly are all manner of first world afflictions. Indeed in respect of some of these, such as high blood pressure, obesity, diabetes, alcoholism, tobacco poisoning, and some forms of cancer, blacks suffer more than whites. And if all this were not enough, blacks are commonly the victims of violence.

This most serious situation is largely due to bad environment, that is, too many people and too much maldistribution of the basic health determinants such as clean air and water, sanitation, housing, electricity, transport, and education. And the causes of the bad environment are social, economic, and political. In particular they are political and rooted in that abomination called Apartheid. Seldom in history have so many people suffered or died in so many ways for so long and in so many places throughout the land - from the impoverished countryside, through the squalid locations and squatter camps around our towns and cities, to the infamous unisex hostels whose migrant inhabitants frequently fall victim to violence and disease, much of which is transmitted back and forth from their disease-ridden communities of origin. This could well explain why AIDS is so rife in Kwazulu Natal.

Much has been written about this human tragedy which has affected millions but the full story has still to be documented. This will be a task for many scholars including I hope scholars of this University. It is right that we should forgive in the interests of reconciliation but we must not forget. We owe it to the victims of apartheid who also are and will be our patients.

You now know, if you did not already know, why we get sick but that is not the end. To complete the diagnosis of our ills, I will tell you why we commonly remain sick and do not get better. I refer of course to the third badness, that is, bad medical services.

These services are not only bad. They are, according to the proverbial man on Mars who has been observing us, also mad.

Consider a few facts, some well-known and others not so well-known:

- Of money spent on health in South Africa, 95% is curative and only 5% is preventative.
- The curative spending is grossly unfair - R18 billion goes to the private sector which caters for only 20% of the population, mainly white. Sixteen billion Rand, that is, less is spent in the public sector which looks after 80% of people, mainly black.
- Two thirds of medical practitioners, 90% of dentists and 90% of pharmacists practice in the private sector.
- Sickness is worst in the rural and semi-rural areas but most health professionals work in the towns and cities.
- Much more money is spent on relatively remote hospitals than on accessible community clinics and much more money is spent in some provinces or regions than in others.

All this is bad enough, but there is worse to follow. What do we get for all the money spent on curative services? Certainly we get some good but we also get a great deal of bad which perpetuates suffering, creates new suffering, and generates an economic disaster called bankruptcy. The situation is especially serious in the private sector where all three parties behave badly - namely the providers including doctors, pharmacists, and private hospitals, the patients, and the payers or medical aids.

Providers and patients are involved in a myriad of devious schemes and scams while the medical aids permit and pay for these schemes and scams. Nobody knows, Ladies and Gentlemen, but my estimate is that up to one half of the R18 billion spent in the private sector is swallowed up by misuse, abuse, and frank fraud.

There are several reasons for this scandal. For one, private health personnel are deeply divided about this private health care which favours neither sound judgement nor ethical practice. For example, some 9,000 dispensing doctors are pitted against about 8,000 pharmacists. And within the medical profession, generalists and specialists compete for sick customers.

For another reason, the cost of medicines is exorbitant in the private sector accounting for nearly one third of the money spent which is between two and four times higher than in most other countries. This is due not only to bad use of medicines, but also to the chain of profiteering from overseas supplier, to local subsidiary or manufacturer, to wholesaler and finally to retailer. And included in this chain is a special South African profiteer whom I have already mentioned, the dispensing or trading doctor.

But perhaps the most potent cause of the scandal stems from the belief, indeed the conviction, of doctors that they must have freedom to act in their relationship with patients. I go along with that but only up to a point. I put it to you, Ladies and Gentlemen, that freedom becomes license when it means the freedom of doctors to:

- practice where and when they wish
- examine (or not) as they please
- investigate patients without reason
- medicate or operate instead of talking to change death-style to life-style
- treat as often and with whatever they wish
- dictate to, rather than discuss with, patients
- dispense and sell what is most profitable to captive consumers
- refer patients to whom they like
- admit patients to their own hospitals as often and for as long as they wish
- finally practice without audit or control.

ALL THIS, I SAY, IS FREEDOM WITHOUT RESPONSIBILITY OR ACCOUNTABILITY AND A RECIPE FOR CHAOS.

In the public sector the medical services are both better and worse. They are better where facilities are reasonable and some therapeutic sense and sanity prevail. But even in teaching hospitals there is sadly considerable room for improvement.

For the most part the public sector services are deficient in all respects: staffing, medicines, equipment and administration. Nor has this been helped by the introduction of limited private practice. What has happened is that virtually all categories of full-time hospital staff up to and including professors have engaged in private practice which is commonly unlimited and takes place outside the hospital with serious and detrimental effects on service, teaching, and research, all matters which are of great concern to the University.

Finally a word on solutions which, as I said, are implicit in my diagnosis. Despite the sad scenario I have described I want to tell you that I am optimistic. And for several reasons:

Most importantly, for the first time in our history we have a democratically elected government which is committed to improving the environment which is by far the most important

determinant of health. Housing, water, electricity, and education will be provided, if not this year, next year, or the year thereafter.

We also have evidence that the population increase is slowing, and this trend should continue with socio-economic upliftment, urbanisation, and perhaps most importantly, the empowerment of women.

The prospects for improving lifestyle are also promising - consequent on better education in general, health education in particular, and pro-health legislation. For the first time we have a government, splendidly exemplified by President Nelson Mandela himself, committed to curbing the merchandisers of death, the tobacco industry. You will be pleased to hear that 1 million South Africans have stopped the dangerous and dirty habit and as many or more may never have started smoking.

In regard to medical services, we all know that the government's priority is the provision of accessible and appropriate primary health care. This is absolutely right and deserves our strongest support both as clinicians and academics. Since the health budget is limited, this will inevitably be at the expense of hospital-based care including that provided by our academic institutions. Many academics are therefore apprehensive but I believe their fear is misplaced. We should accept this as a challenge and an opportunity. As already alluded to, there is a great deal wrong with medical services at our academic hospitals. With rationalization of procedures, the setting of priorities, and proper audit and control we can deliver better health care at lower cost. And our teaching hospitals and staff can generate income from the private sector in ways which will genuinely benefit the whole of academia.

In the private sector also, we shall do better as madness is replaced by one or other form of managed health care based on a partnership of providers, patients, and payers.

ALL IN ALL, LADIES AND GENTLEMEN, I BELIEVE WE WILL WIN
AND I CALL ON THE GRADUANDS OF 1995
TO BECOME PART OF THAT TRIUMPH.