

Letters

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E-mail consultations in general practice

E-mail is an established method of communication in business, leisure, and education, but not yet in health care. The medical profession exhibit a polarity of views on e-mail, ranging from enthusiasm at a medium based around users' convenience, to hostility based upon concerns about security and intrusion into clinicians' work patterns. We used a qualitative analysis of interactions and an electronic user survey to evaluate a practice e-mail service for repeat prescription orders, appointment booking and clinical enquiries.

Among the 150 patients, aged 24–85 years, who participated, satisfaction with the service was very high. Patients specifically commended the practice for setting up a facility to allow communication outside standard working hours and for the ease of ordering repeat prescriptions. Patients were pleased to have a means of seeking their doctor's comment or opinion without bothering him or her by making and attending a formal face-to-face consultation. E-mail dialogue was polite, factual, but less formal than standard letters.

Use of an e-mail consultation facility worked well within an urban practice, was deemed helpful by patients, and had no apparent increase in GP workload. Our results suggest that there may be an unmet need among patients for clinical e-mail services, and that such services may have positive outcomes for patients and practices.

A detailed description of methods is shown on: <http://www.show.scot.nhs.uk/gpsites/t/11132/home.htm>.

We should welcome comment and discussion.

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Differences in health care in South Africa and the UK

We read Dr Kruger's comment on the difference between health care in South Africa and the UK and the stinging rebuke that, should he become ill, he would fly back to South Africa for his health care, with some concern.¹

His reflections are based on the power of the market and the perils of 'socialist' medicine. We suspect, however, that he writes from the perspective of the economically advantaged healthcare consumer in South Africa. Such a consumer can benefit from the power of the market, which has made high technology and interventionist medicine more readily available in South Africa than to similar people in the UK. But let us compare the case for the economically less advantaged healthcare user in both countries.

In the UK, whether in urban deprived areas of the inner cities or in the economically disadvantaged parts of the rural hinterland, everyone has access to interventionist high-tech medicine. Perhaps access is not quite so timely or the care provided in quite so pleasant an environment as Dr Kruger can access in South Africa? But can he say that everyone in Soweto or Transkei has access to health care, which the economically advantaged in South Africa enjoy, when 85% of people in South Africa have no health insurance?

We acknowledge that health care in the UK chafes under a huge burden of bureaucracy and that frontline healthcare staff often feel they are outnumbered by the 'Elevator People'; there are delays in access and the care environment can often be improved. However, we must not lose sight of the simple truth. The UK's much derided socialist and imperfect NHS has succeeded in delivering first-world

care to all its people, whether they have the economic clout to access the healthcare market or not.

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References

1. Kruger A. Decisions and elevators. *Br J Gen Pract* 2004; **54**: 398.

Author's response

I can hardly agree more with a viewpoint than with this of my esteemed colleagues. Our only possible difference is the best way to achieve the same end.

Their 'suspicions' about my economic position and what I 'can access', however, appear prejudiced and stereotyped. Actually one of 'the 85% without health insurance' myself, I have empathy with those in the same situation. Offering my services, and often medicines, for free where the need was obvious, taught me how much more the same resources can achieve in the absence of 'management' by bureaucracy.

But also, I noted how much better medical intervention worked when the patient took 'ownership' thereof by paying, even if with a chicken or a few vegetables from their country garden ...

It likely makes political sense taking credit for supplying services to 'all', and economic sense using other people's money (tax) to fund it. If the objective is purely philanthropic, however, surely we should all endeavour to find ways of getting maximal 'mileage' out of every penny spent.