Letter from . . . Dunedin

There is a hole in your bucket, dear Minister

A G HOCKEN

Unemployment, the street polls tell us, is a matter of major concern to the electorate, and this is election year. The present official figure is about 50 000—a little over 4% of the work force. Inflation exceeds 16% and the prophets of doom—are economists ever anything else?—forecast that it will reach 20% within a few months, an assertion that the Government stoutly denies. Government expenditure on health and sickness services totals a little over \$1533m—"the finite cake" of the health vote. Wrapping this cake are several problems intertwining.

A basic rankle is over the sharing of the cake, particularly between the hospital and primary care services. About three-quarters of the total sum is diverted to hospital expenditure. Basically, hospital treatment is free to New Zealanders. In general practice remuneration is on a fee-for-service basis, supplemented to a greater or lesser degree by Government benefits of which the basic one—general medical service benefit (GMS)—is \$1.25 for a routine consultation. There are many variations, such as increased benefit for "out-of-hours" work, for pensioners, and for children. Further benefits recognise the use of radiology, physiotherapy, and laboratory services, but we tend to judge things by the baseline GMS benefit of \$1.25. Understandably, perhaps, the general practitioners think that the 3% of the health vote that this sum represents puts their service at a disadvantage. This is only part of the cost of "medical service" which took up about 13% of the cake in 1974. The general practitioners' argument comes into focus when you recognise their present need to charge \$10 for a consultation. This is not a fixed sum, but represents a fairly standard charge. The GPs are anxious that an increase to the GMS is not seen as avarice on their part. They emphasise that the Government's contribution is a patients' benefit to be set against the total fee and not in addition. Already the increased cost to the patient is having an adverse affect as there is mounting evidence that patients are baulking at paying \$10. Though people spend untold sums on the self-destruction of tobacco and alcohol, \$10 really is a significant amount out of the average family weekly income of \$220. Some patients are seeking general practitioner services in hospital clinics.

It has been estimated that if the Government persists in the benefit scheme and general medical services are to be maintained at their 1941 level, the State's contribution will need to be increased to \$7.50. That would cost about \$35m nationally. One concept is that the benefit should be used as a hedge against inflation, and be adjusted annually. Other means of paying for health care may be considered. One is that the Government should opt out entirely, leaving the user to pay, supported by private insurance schemes, a growing facet of life. For this to be acceptable, however, premiums would have to be tax deductible. Insurance and superannuation premiums as tax benefits are a privilege of which we see little. Mortgage contracts attract no

sympathy from the tax man. The third alternative being spoken of is that of a salaried or capitation fee service, free to the user at the time of consultation.

Fear of emulating NHS

The older generation of doctors tends to resist the last concept; they are fearful of emulating the tendencies that the British National Health Service has shown. In underpopulated, isolated, and, therefore, unpopular practice districts some areas are already designated and the Government pays a fixed salary ranging from \$30 000 upwards by negotiation; basic consultation is then free to the patient. My younger colleagues tend to favour a salaried service. These are people at present in junior hospital posts who are used to the orderly appearance of their monthly bread. It has an appeal of security about it, I imagine. Anxiety about security of income from general practice may be understood today with the prospect of 800 surplus doctors by 1986.

Hospital services are provided by 29 boards which have an enormous range of responsibility in the size of the populations they serve and over the area in which those populations live. Hospital boards receive a direct grant annually from the health vote. The Minister of Health has created consternation by a proposal to redistribute the moneys, to slice his cake differently. The proposal is to reallocate funds by using the reduction of income to some boards to supplement that of others that are considered underprivileged. The local press reports that in Dunedin, the Otago Hospital Board's cut of \$7.5m represents a loss of 12.3% out of its \$62m annual budget, to be applied over six years. A later editorial resubmits this as a total loss of \$9.75m costing 600 jobs over the longer term. It is probable that the precise costs and exact effects are not known and are not immediately calculable, but that they would be "significant" is unquestioned. The fact is, of course, that Otago Hospital Board's budget has seemed so generous in the past, compared to those of its colleagues, that a reduction rationalised to a per caput income is going to hit that board quite the most severely of any other authority in the country.

I have already referred to the traditionalism embodied in such allocations to date. The strongest of these lies in the University of Otago Medical School. Its establishment was in a very different national climate 106 years ago, when Otago was the economic and population centre of the colony, riding on the crest of the gold boom. Until 1970 it remained the only medical school, despite the "drift to the north" which has depleted the population of the Otago Hospital Board's area to a mere 4% and its regional service area to 9.3% of the national total. The maintenance of a well-established preclinical and clinical medical school in the middle of a multifacultied university in an area of low population is the main reason given for what is regarded elsewhere as the overprivileged funding that Otago Hospital Board has received to date. Local rationalists put it simply that if the Government wishes to maintain the medical school in Dunedin, it is going to have to support it. The minister's assertions that the hospital board reduction in income

would not affect the medical school because that is funded from the education vote is seen as being naive and is undermining confidence in his rationalisations.

Wallace Rowling, the Labour Party leader, was reported as indicating that while he supports the concept of hospital board funding on a population basis, Otago's position is peculiar in several respects. He recognises the relationship of the hospital board to the medical school as traditional, but finds it compelling, as is that of the university to the town and community welfare. Because of these needs "an incoming Labour Government would negotiate additional supplements to the Otago Hospital Board."

This is all heady stuff that could turn a young voter's cross, but the more cautious might just recollect that it is only two elections since the famous baby bounty offer. In 1975 the same leader of the Labour Party promulgated the offer of a \$500 benefit to the parents of every child born within 12 months (more or less) of Labour's accession to power. This only earned the party, which was in power at that time, much derision and a return to the opposition benches.

Junior doctors' problems

A parallel issue to that of the board funding but still cross linked by the matter of money and that finite cake, is that of junior hospital staff, the resident medical officers (RMOs). The British style of medicine has moved a long way from the days when the advantage of a London teaching hospital appointment was taken for a six-month sentence without the privilege of time off. Not so long ago in the 1960s the terms of service of my first registrar appointment in an eminent provincial hospital allowed me one weekend in four as my only free time as of right. Now our young people are resisting these impositions of questionable necessity and dubious justification.

The introduction of overtime payments in 1969 has foundered on two bases at least. Firstly, the RMOs have found that such added income is not a satisfactory substitute for free time, time which they can call their own to get out of the hospital to see their families and to grow up with their children. Secondly, because they were so unconscious of sensitive hospital administration, employing authorities are finding that extra-duty payments are nibbling into their finite slice of cake. From my ivy-clad ivory tower I was amazed to learn that some hospital boards are still expecting 168 hours of responsibility and four-day working weekends from the RMOs. It is reported that more than 95% of RMOs are rostered for more than 60 hours a week

and many for more than 80. With the increased work load—beds by 15% and admissions by 35% over ten years—and the accelerating technology that places great demands on all of us, it is not surprising that there have been mutterings from between decks.

Despite a series of compensations, reports, and recommendations in 1969, 1977, and 1978, note has not been taken of the writing on the wall and it has only been threat of "industrial action," principally from the Auckland RMOs, that has led to the report of yet another working party. A few weeks ago the Hospital Medical Officers Advisory Committee of the New Zealand Medical Association, working with the Ministry of Health, reported on the working conditions of RMOs. The 16 recommendations concerned the number of hours that should be worked and on call, weekend duties, half days off, and rights to annual leave. I think my first point, the most prominent matter of dissension, has been well summarised by the *New Zealand Medical Journal's* comment that while a one-in-three rota (84-hour week) could be reluctantly accepted in the smaller units, the current ideal would be a 75-hour week with sights set to a 65-hour week or a one-in-six rota as the ultimate aim. But the implications behind the need for the opening sentence of recommendation 3, "No resident medical officer should be required to work a one-in-one roster (168 hours) . . ." is thought provoking indeed in 1981.

The report concludes that there is a shortage of RMOs nationally and recommends that at a cost of \$1.26m annually 54 new posts should be created, of which 31 would go to Auckland with the remainder scattered elsewhere through the country. This recommendation it is understood is already accepted and under implementation. You might think that that would be no great problem at a time when our young people are faced by the prospect that in 1986 there will be 800 doctors more than the country needs. That sum of \$1.26m, however, has got to come from somewhere; nobody at this time believes that it will grow on a tree, but that it will have to come out of the same old cake. So whose slice is going to get thinner, and who is going to be resentful at even more money going to hospital services? In 1986, with the specialist colleges having carefully tailored their admission success rates to ensure that excess manpower is not creating a superfluity for the specialist market, the remainder will, *faute de mieux* (which is the worst of all possible reasons), need to go into general practice, whose minuscule slice would then seem to have to be even more finely divided. Thus we come full circle, too little cake to be divided into too many slices and with too many opinions on the best means of doing it. "There is a hole in your bucket, dear Minister. . . ."

A 38-year-old man says that for two years, starting two years after a vasectomy, he has often experienced sudden severe pain in the right testicle, groin, and lower abdomen at the moment of ejaculation. The pain is not invariable, but is felt only after a period of abstinence for a week or more. It lasts under five minutes, and makes him want to defecate. He does not do so, but feels relief from sitting on the lavatory. There is no abnormality on examination of the genitals, spermatic cord, or prostate, and he is mentally and sexually normal. What is the cause, and is there any way of relieving his symptoms?

The history of vasectomy is probably coincidental, and the patient's symptoms are prostatic. The most likely condition is an abacterial prostatitis, which often presents no specific features on clinical examination, including rectal examination. It might be advisable to culture the semen and to confirm that the urine is sterile. The condition is tedious but tends to cure itself after a year or two. A prolonged course of co-trimoxazole/trimethoprim/sulphamethoxazole (Septrin) over some four weeks, combined with an anti-inflammatory agent such as oxyphenbutazone 100 mg thrice a day, might help. In view of the relation of the symptoms to abstention from intercourse

for a week or more it would seem practical to advise him to enjoy intercourse more regularly.—G BARRY CARRUTHERS, consultant urologist, London.

Patients given antibacterial drugs sometimes display trivial "allergic" manifestations (rashes etc). Is the antibacterial effect of the drugs lessened by the occurrence of such allergy?

Rashes occur with many antibacterial drugs. Some are "allergic" but for others the mechanism is unknown. The common ampicillin rash, for example, is not a sign of allergy to penicillin. So far as I know there is no evidence that these reactions are associated with loss of antibacterial effect. Indeed, on occasions when it is thought necessary to continue treatment with penicillin despite the occurrence of allergic reactions—for example, when treating bacterial endocarditis—specific hyposensitisation allows continuation without any apparent loss of effect.—LINDA BEELEY, consultant clinical pharmacologist, Birmingham.