Letter from . . . Sydney

Crises down under

PETER C ARNOLD

British Medical Journal, 1979, 1, 107-108

It might be difficult for doctors who are unaccustomed to fee-for-service systems to appreciate why the details of who pays whom matter so much in Australia, as in Canada and the USA. It is perhaps more important than how much is paid for what. Australian federal governments have been formally concerned in fee-for-service payments to private doctors since 1952. Originally, the government was willing to meet a third of a patient's medical bills, provided that he belonged to a non-profit mutual fund that likewise paid a third, leaving him to find a third from his own pocket.

Australian socialists found this inequitable, since the rich, the middle class, and workers alike had to meet both equal premiums to the funds and equal third shares of bills. (Pensioners were covered by a direct payment scheme between government and general practitioners, with specialists caring for them on an honorary basis in the public hospitals.) Accordingly, when the Whitlam government finally emerged from the political wilderness they brought in a system of tax-based financing related to a percentage of taxable income. Against their own fundamental principles they retained fee-for-service, believing that the people would not accept a sudden transfer to their preferred salaried system. Australia's Medibank was a faithful copy of Canada's Medicare. Unluckily for Whitlam, a credible and substantial body within the medical profession had already developed in Australia that opposed the "official" Australian Medical Association.

Strength through diversity

This opposition ranged from the General Practitioners' Society—at its peak representing almost 20% of private practitioners, a body totally dissociated from the AMA and refusing to be represented to government or, more importantly, via the media to the public through the AMA—to more moderate bodies such as the Australian Association of Surgeons and the National Association of Medical Specialists. The last two were formed later than the GP Society and retained affiliation with the AMA, though disagreed in many major policy areas.

A quirk of the Australian Commonwealth Constitution prohibits "any form of civil conscription of the medical or dental professions." Just what "civil conscription" means is anybody's guess. It is, at worst, self-contradictory, "conscription" being a military term. It had its origins in Constitutional protection for trade unionists. But it was clear enough to a majority of High Court judges when the BMA challenged the

pharmaceutical benefits legislation in 1948. The government was foiled in its attempt to force doctors to prescribe according to its dictates. No Commonwealth government has since been game to try coercion, as much as they might have wished to, since 1948.

Any hopes government might have had of fee-fixing were dashed by unilateral action taken by the GP Society in 1972, in which it recommended its own fee scale. After much brandishing of threats, the Liberal (conservative) government settled on a judicial arbitration on the reimbursements to be paid to patients for each item of service. Actual fees charged were left as a matter between patient and doctor. The judicial arbitration, boycotted by the GP Society, has become a gentlemanly annual settlement between the government and the AMA.

Five new crises

Australian medicine now faces five interesting crises, with medical opinion split between the "free enterprise" GP Society at one extreme, the infant socialist Doctors' Reform Society at the other, and the Australian Association of Surgeons, the National Association of Medical Specialists, and the AMA, each of which occupies various positions along the line between.

Unlike almost every other democracy where governments have successfully introduced socialised (that is, state-financed) medicine, the Australian government lacks the advantage of having only to "con" one medical hierarchy in order to "trap" the entire profession. There is no body in Australia that today commands the esteem of the profession, the public, and the government alike, as was the case in the UK, Canada, Sweden, New Zealand, or Denmark, to choose a few among many examples.

The new High Court challenge

The GP Society is challenging the government's recent amendments to the Health Insurance Act in the High Court. These changes were meant to eliminate abuses, kick-backs (dichotomy), and sundry other rackets. In trapping a few cheats, the Commonwealth has gained effective control over all pathologists, who have been compelled to sign an undertaking not to cheat. Had any pathologist refused to "undertake," his patients would have been denied insurance rebates on his fees. In a country where rebates are paid on all medical expenses, any pathologist defying the government would soon have had to close his practice.

Not only were pathologists (honest and dishonest alike) forced to "undertake," but they had to agree that the terms of the undertaking could be varied by the Minister at his absolute discretion, without consulting the pathologists or seeking their agreement. The Minister is now in a position long sought by previous governments: he can control the conditions under which private pathologists may work and the fees they may

charge. He already exercises this authority over optometrists, whose fees now attract insurance rebates. If the GP Society's constitutional challenge fails, the way might be open to government control of every branch of the profession.

Recent AMA moves to limit foreign graduates entering the country and the number of new Australian graduates may be agreed to by government. After years of a doctor "shortage" now that there is a possibility of a "surplus" the AMA fears for the economic viability of its members. A vigorous challenge has been launched by the GP Society, arguing that the mere possession of an MB parchment is no guarantee of any right to earn a living in the market place; competition can lead only to higher standards and perhaps to some stabilisation of fees. The AMA's moves parallel those in Canada, where it is being suggested that not only should the numbers of immigrant doctors and new graduates be cut down but that all doctors should mandatorily retire at 60.

Cost-control versus peer review

Threatened by the Commonwealth government with some undisclosed controls if it didn't come up with some means of controlling rising health care costs, and after years of protesting that it really wasn't in favour of "peer review" (known in the United States as professional standards review organisations), the AMA has placated government by favouring what it calls "quality assurance programmes." Many in the profession, especially the more academically minded, think that some supervision of their colleagues' practice of medicine is desirable, so that the few rotten apples can be thrown out. But QAPs are the least of the government's concerns—as with all governments, it is concerned with its dollars. Political observers may gleefully anticipate the confrontation when those doctors not in the AMA hierarchy come to realise that the government is interested in controlling costs, while the AMA is talking about control of quality, and that the two are virtually diametrically opposed. The better the control of quality, the more, not the less expensive, the service; the more cost control, the less the quality of service.

The accession of a conservative government late in 1975 meant a piecemeal demise of the monolithic Medibank system. This has now undergone the many changes that may be expected when a non-doctrinaire government tries to break up a well-planned and efficiently executed socialist scheme. The perennial problem of non-socialists is that they don't share the socialist dogma of a Utopian scheme that *must* work. The latest moves have upset the AMA hierarchy, who fear that increased patient responsibility for medical fees might lead to increased bad debts for their members. The GP Society is delighted that patients are being forced to realise, through the hip-pocket

nerve, that medical services are costly, and that "there ain't no such thing as a free lunch" (TANSTAAFL). The socialist Doctors' Reform Society is bitterly unhappy that their members' fees-for-service will be underwritten to the tune of only 40% by the government for uninsured patients. The likely possibility that many Australians will opt for hospital insurance alone, carrying their own medical insurance in the secure knowledge that the government will subsidise all but \$20 of any expensive medical service, is sending waves of terror through the AMA and the non-profit health insurance funds.

Almost as if to say "for we are jolly good fellows," the AMA hierarchy, without consulting its members, has offered to the government a postponement of the 1978 annual revision of reimbursements, with a promise to ask its members not to raise their fees before January 1980. The media and the government joined in the general acclamation of this altruistic move, a mood not shared by many AMA members, who were fed up with the AMA's repeated compromises with government "in the public interest."

Where should John go?

Australia's medical man(woman)power problem defies the soothsayers. The official 1974 Karmel Commission reported a grave shortage and encouraged an increased intake of students and the establishment of a new medical school. The commissioners seemed unaware both of world politics and of Australia's declining birth rate. The universities, in true egalitarian, anti-élitist fashion, opened their doors widely to the top 2% of each year's Higher School Certificate (matriculation) candidates, regardless of other criteria of their suitability or otherwise for medical practice. On the credit side, then, Australia has increasing numbers of medical students graduating each year from now on, an additional year's graduates this year with the change from a course lasting six years to one lasting five, and an influx of doctors from India, Pakistan, Rhodesia (Zimbabwe), and South Africa (Azania). On the debit side, close on half of Australia's medical students are women—just how full-time their careers will prove to be will vary as each struggles with her "maternal" instincts. Only a foolish man (or a professional planner) would try to forecast our man(woman) power in the next decade or so.

If John is thinking of leaving mother UK for overseas pastures he should think carefully before setting off for the "lucky country." He may find that his British degree is not recognised, that he cannot get a working visa, that he has to sit an exam to prove that he's good enough for Australia, and, last but not least, that there are no jobs available.

(Accepted 27 October 1978)

I have carried out many pre-employment tuberculin tests on young people. About 80% of those who say that they have been given BCG at age 12 or 13 have a negative response to the Tine test. What advice should I give them?

The Tine test has been shown by the Research Committee of the British Thoracic Society¹ to give very unreliable results in comparison with the Mantoux test with 5TU. Of 307 people, 59% were positive on Mantoux testing while only 3.9% of the same people were definitely positive with the Tine test. It was concluded that the Tine test was unsuitable for epidemiological work and its usefulness in clinical practice very limited. In carrying out pre-employment screening a history of BCG vaccination with the presence of a scar can be taken as evidence of this protection without further testing. In cases of doubt some centres hold records of BCG vaccination that can be easily checked, but unfortunately in other centres these have not been adequately maintained. In the absence of evidence of protection

Mantoux testing is advisable and BCG vaccination advised for those at risk of exposure to tuberculosis who give negative results on Mantoux testing.

¹ Lunn, J A, and Johnson, A J, *British Medical Journal*, 1978, 1, 1451.

Correction

A mantle of safety: the 50th year of the Royal Flying Doctor Service

In this paper by Professor J C Shearman and Dr Allan Limmer (5 August, p 407) the aircraft shown in fig 2 was wrongly described as a Piper Navajo Chieftain: it is in fact a Beechcraft Baron.