secretaries who assisted in the collection and coding of information, and to Mrs A Avery who carried out the statistical analyses.

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Letter from . . . Victoria

Funding of medical care

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The past few years have seen many changes in the funding of medical care in Australia. In July 1975 the Labour Government introduced Medibank. Medibank was a logical step beyond the multitude of health insurance organisations that had up till then provided for the medical costs of Australians. Medibank, which was in effect a government insurance scheme covering everybody, was introduced in the teeth of the Opposition's opposition. The Opposition controlled the Senate and refused to pass the legislation that would have funded Medibank by an extra levy on income tax. Nothing daunted, the Government funded Medibank from consolidated revenue. So the new universal scheme was introduced as a "free" service.

In November 1975 the Governor-General, relying on a literal reading of the constitution and paying no attention to precedent, dismissed the Labour Government while it still had a majority in the House of Representatives. What precipitated this action was the refusal of the Opposition to allow the supply bills to be debated. This meant that the Government was soon to be out of funds.

The Liberal (in English terms Conservative) party won the ensuing election and set about cutting government spending. Among the many casualties was the "free" Medibank. In October 1976 the idea of a single universal insurance scheme was discarded. At the same time a levy (anathema to the Liberals when in opposition) was introduced to pay for Medibank. This levy was set, in the name of freedom of choice, at a higher level than the various benefit societies were to charge for basic hospital and medical cover. Moreover, the contributions for health care insurance were no longer to be income-tax deductions. The whole cost of his medical and hospital insurance,

which he is now compelled to have, was to be borne directly by John Citizen. All trace of government subsidy was removed for the average citizen, only pensioners and the very poor being excused from the levy.

At the same time new regulations were introduced about direct payment to the doctor from Medibank. Under Medibank I (July 1975 to October 1976) the patient could sign a voucher in his doctor's surgery and the doctor could then claim the rebate, and only the rebate, from Medibank. Some bad apples in the medical applecart took advantage of this form of open cheque and charged for services not rendered. One such was recently prosecuted for having falsely claimed about \$250 000. He was convicted. Later he was struck from the register by the medical board of his State. About a dozen doctors have been prosecuted for falsely claiming large amounts. Some indicted themselves by claiming for several prolonged consultations (over 45 minutes) a day. Unfortunately they must have had days longer than 24 hours to fit in all the consultations. The Medibank computers found these very long days difficult to believe.

Now the patient may still sign a voucher for direct payment of the doctor, but the patient has to be given a copy of the voucher so that he knows what service was rendered—or perhaps so that the Medibank checkers can call to see that the carbon copy corresponds with the original. My own view is the latter. Mercifully, the vouchers are "no carbon required" paper.

Malpractice in pathology services

Malpractice was also noticeable in the pathology services. In the Australian system there are private pathology services in parallel with the hospital pathology services. The private services provide for most of the population, as the hospital services only provide for their own inpatients and outpatients. The private services are owned either by the pathologist or by companies that employ pathologists. The fees set by the Labour Government were those prevailing before Medibank. At much the same time as Medibank was introduced pathology services were going over to automation. To use the machines most efficiently many tests on each specimen were needed. So some

unscrupulous operators—so far as one can tell they were the non-medical owners of pathology services—encouraged multiple testing. Remember that the fees were those reasonable with manual testing, so multiple testing quite legally generated large incomes. While battery testing probably does nothing much to improve medical care it certainly raises the costs. It was even said that doctors in New South Wales were encouraged to use a particular laboratory by having a nursing sister attached to the practice at the laboratory's expense. Even more direct bribes, such as trips overseas, have been mentioned.

The laboratories were accepting the patient's signature on a blank Medibank voucher that was later filled in by the laboratory, and payment was claimed direct from Medibank. The payments were guaranteed. There is no doubt that much overtesting occurred but no overcharging in a strict legal sense. The unscrupulous laboratories merely used the system to their advantage.

Faced with a soaring pathology bill the Government and the AMA formed a joint working party. This committee recommended some changes in the fee structure of pathology tests by reducing most fees to levels suitable for automated testing and lumping many tests into groups where the same rebate was paid for one or more tests.

Recently further changes have come into force. All providers of pathology tests must be approved by the Government if the patient is to get any rebate for his outlay. To encourage economy in the use of pathological tests, every request must now be handwritten by the doctor who signs the form. Legibility must suffer to keep costs down. The request forms must be kept for 18 months by the laboratory so that they are available for later checking.

Big Brother's shadow

Recently the health benefit organisations have written to doctors asking them to put their "provider code" on their account forms. The "provider code" is a Medibank computer identification for each doctor in Australia. For reasons I have not been able to fathom one is given a different code number for each practice location. So the doctor with three surgeries has

three provider code numbers. These numbers enable the computers to keep track of the claims made by his patients for repayment of fees charged. The computer can build up a profile of the doctor's consulting habits and of his pathology ordering. If the code number is not provided the claim for the rebate may be rejected.

Before the Government lifted the cost of health insurance off its broad shoulders and placed it firmly on the individual's plate only Medibank and its computers were interested in provider codes. But since October 1976, when many people were forced to insure with the private funds, the paper-work load has risen. To quote from a letter recently sent to all doctors in Victoria by the Health Benefits Council of Victoria, "As you well know, changes to Medibank and new requirements for the operation of private health funds introduced last October have resulted in much confusion, more complications, and greater delays in settlement of medical claims."

Before Medibank the funds were subsidised by the Government, which paid about half the cost of the rebates for medical bills. In those days the Government required accounting in bulk for the money supplied. While Medibank I was working the health benefit organisations were restricted to providing insurance for hospital costs. In October 1976 they were allowed back into the medical fee insurance business but with an obligation to pass on to the Medibank computers all the details of every bill that went through their hands. In this way the central authorities, in the name of competition and saving costs, have forced an extra, expensive, and inconvenient layer of bureaucracy into the health insurance business.

However one looks at this gathering of statistics, Big Brothers' shadow is visible. What need has the Government to know how many patients I see each week and how long it takes to see them? The time taken can be calculated from the fees charged as these are different for brief (less than 5 minutes), standard (5 to 25 minutes), long (25 to 45 minutes) and prolonged (over 45 minutes) consultations. What need is there for the Department of Social Security to know my professional earnings? The legislation barred this information from being passed on to the income tax authorities. Plastering the wounds with a layer of bureaucrats seems an expensive way of trying to control the costs of health care.

I have found disopyramide useful in treating cardiac arrhythmias. One of the side effects is blurred vision. If a patient develops this is it advisable to stop the drug?

Blurred vision is a predictable result of the anticholinergic activity possessed by disopyramide. After excluding organic eye disease some modification of the dose may well reduce or prevent the adverse effect. Stopping treatment is not mandatory.

A 3-year-old child has had recurrent bouts of severe chest infection for 18 months. What investigations are recommended and how might he be treated?

It may not be possible to find the cause of these recurrent chest infections. Given that the child has not got asthma (which would be eliminated by the absence of signs of bronchial spasm) and the sweat test was properly done (thereby eliminating fibrocystic disease of the pancreas) the cause of the persistent changes must be looked for in the right middle lobe. Bronchiectasis is rarely seen now in Britain, but it must be eliminated. A bronchoscopy would eliminate a foreign body or other obstructive lesion in the bronchus, and a negative Heaf test would exclude tuberculosis. It would be wise to eliminate chronic antrum infection both in the child and the rest of the household which may be acting as a reservoir of infection. If nothing else is found

immunoglobulin and perhaps the phagocyte function should be investigated.

Twenty-five years ago whooping cough was treated with chloramphenicol with reasonable success. Is this still a satisfactory treatment?

The clinical course of whooping cough, by its very nature and by its varying severity and variable course, makes it difficult to determine the effectiveness of treatment. Antibiotics do not alter the clinical course,^{1,2} except perhaps for treating complications, but they do shorten the period of infectivity. Erythromycin was more effective than chloramphenicol or tetracycline in reducing this period.¹ Chloramphenicol, ampicillin, oxytetracycline, and erythromycin were compared with no treatment and the clinical course was the same in all five groups.² Shirkey³ wrote that antibiotics are used for epidemiological rather than therapeutic purposes—that is, for reducing the period of infectivity—and I agree with his further comment that "chloramphenicol is not used because other less potentially toxic drugs are equally effective." He advocated that erythromycin (40 mg/kg/day) should be used only to reduce the period of infectivity. Chloramphenicol should not be used because of the risk to the bone marrow and because it is ineffective.

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