authority clinics and others to health centre clinics for cervical cytology? Should ambulance and British Red Cross services be drawn into health centres or separated from them? One could go on. Central direction is overdue. A waste of money and manpower is bad enough, dividing the patients' total care is worse.

So far I may have seemed to be guilty of emphasizing the mistakes and deficiencies of the health centres I have visited. This was not my intention; local authorities and family doctors initiating these centres have done so with the best of intentions and with all the available knowledge at their disposal. No one can work to a central plan, because one does not exist. Some centres are deficient in some aspects of care and strong in others. Facilities are available in some and

absent in others. Thus different populations of patients have different qualities and degrees of care and this is quite improper.

Even though different areas may call for variations in siting and planning, these should be based on certain principles which are now clear: total care through total attachment; all activities designed to cover the whole care of the whole patient from the cradle to the grave attainable in the same centre, and not duplicated or triplicated in other buildings under the charge of other doctors and paramedical personnel. A centre represents the concentration or marriage of all those personnel and disciplines involved in the overall medical care of the population in its totality, from the stage of prevention of disease through to aftercare and follow-up.

OUTSIDE EUROPE

Medical Care in Australia

R. J. KNIGHT,* M.B., F.F.A.R.A.C.S., D.OBST.R.C.O.G.

British Medical Journal, 1970, 2, 356-357

Australian medical care is organized differently from medical care in the United Kingdom. In Australia the patient pays his general practitioner. Should a second opinion be necessary the G.P. refers the patient to the specialist of his choice who will charge his fee. To cushion the financial blows the patient can join one of about 110 medical and hospital benefit societies. Only if he is a member of a benefit society will he be entitled to a Commonwealth subsidy towards his medical costs. The benefit society must add at least as much as the Commonwealth pays; the total rebate, however, is limited to 90% of the doctor's bill. Pensioners get free medical attention and drugs, the doctor being paid by the Government on presentation of a voucher signed by the patient.

Should the patient require admission to hospital financial hurdles are once again raised. Only those who can pass a means test can be public patients whose medical care and drugs are provided free. They still pay for their board and lodging. Those who do not take or fail to pass the means test pay their doctors, whom they have personally chosen, and also pay for their drugs and a higher rate for bed and food. These costs can be guarded against by insuring with a benefit society.

When the health benefits scheme, often known in Australia as the National Health Scheme, was introduced the gap between benefit and fee was modest. Steady inflation over the past 20 years, combined with the increasing complexity of medicine, has led to a constant rise in costs. The cost of running a general practice has been increasing at more than 3% per annum for at least the past five years. Doctors' fees have risen, but the take-home pay is unaltered, the increase in total income having been swallowed by extra costs. In effect this means a decrease in the doctors' purchasing power as the Federal Government admits to inflation of about 3% a year. The Government has not altered most of the subsidies during the past 10 years, though it has agreed to higher payments from benefit societies, which has meant higher

premiums. By 1969, when benefits were averaging 50% or less of medical costs and were also failing to meet hospital accommodation costs by a large margin, it became obvious that an overhaul was necessary.

Policies of Political Parties

What should be done? The Liberal (Conservative) Government, backed by the Australian Medical Association (A.M.A.), praised the present voluntary system with its emphasis on self-help and its sturdy antisocialism. The Government blamed the doctors for raising their fees, conveniently overlooking the Government-inspired inflation that constantly raises wages and costs. The A.M.A. blamed the Government for failing to raise their contribution to the health scheme to meet rising costs.

The Labour opposition countered with a comprehensive plan for the rescue of hospital finances as well as the payment of medical fees. Public hospitals are financed by State Governments, whose financial responsibilities include hospitals, education, roads, public transport, cheap housing, urban renewal—in fact, everything except defence and foreign affairs. The States have been faced with rapidly rising essential expenditure, due to immigration and natural increase in the population, and a much less rapid rise in income. The Federal Government is the only collector of income tax, leaving the States without a tax whose return rises as the community's income rises. Grants to the States are increased each year, but often the increase is almost all conditional on the State Government spending an equal amount, or in education twice the amount, on specified projects. This system of matching grants bears heavily on the States, whose income is barely enough to maintain their inadequate services. Hospital buildings can often be constructed, but there is no money for extra running expenses, such as paying the honorary medical staff. The Labour party plan was for the Federal Government to accept the responsibility for hospital costs and at the same time pay those doctors who

* Honorary Assistant Anaesthetist, Royal Melbourne and Alfred Hospitals, Melbourne, Australia.

now serve as honoraries. Most specialists give at least three half-days a week honorary service to either a teaching or a district hospital.

For medical fees the Labour party recommended one national benefit organization in place of the 110 or more at present existing. This was attacked as a monstrous monopoly by Government spokesmen, but to their embarrassment the Nimmo Committee, appointed by the Government to recommend improvements in the N.H.S. while preserving its present voluntary character, suggested that there should be at most one benefit organization in each State. The Labour proposals were attacked as "nationalization of medicine" by the A.M.A., horrifying parallels being drawn with the N.H.S. in the U.K. For unknown reasons comparisons were not made with New Zealand and Saskatchewan, both of whose medical payment schemes resemble the Labour party suggestions. The great asset of the Labour proposals was that those who are uninsured because they cannot afford to pay the premiums would be covered.

During the 1969 election campaign the Liberal Government promised to pay the contributions of those families below the poverty line if they applied to a benefit society. This has recently come into force. There is also a review of medical benefits and a new schedule of subsidies in the pipeline.

G.P.s and Specialists

The B.M.A. has its troubles with junior hospital doctors. The A.M.A. is having trouble with G.P.s. Specialists charge more for their services than G.P.s do, but the medical benefit returns have always been the same whoever rendered the service. This was an obvious injustice to the patient, and the A.M.A. has been trying for some time for a differential rebate, and at last the Federal Government has agreed. This raises the question of who is a specialist, and some, but not all, of the States have established specialist registers. This is a State responsibility as there is no G.M.C. in Australia, only State registration boards. The recent publication by the A.M.A. of a list of most common fees for doctors' services, split into G.P. and specialist, has brought down coals of fire on the A.M.A. Federal Executive. Both the Royal Australian College of General Practitioners and the Australian Society of General Practitioners have denounced the list as making the G.P. a second-rate doctor. Spokesmen for the R.A.C.G.P. have claimed that when there is no financial deterrent patients will go direct to specialists and that procedures traditionally done by G.P.s (tonsils and adenoids, appendectomy, midwifery, etc.) will be done by specialists in future and, because of the differential subsidy, at greater cost to the N.H.S. Only in private do they mention the real bogey. They see a possible loss of income. In fact, many doctors with higher degrees in medicine and surgery are in general practice and would be on the specialist register, at least in some States.

Proposed Changes

The Government intends to abolish the multiplicity of benefit tables and introduce one table, at an increased subscription, that will leave the patient to pay about \$1.00 (9s. 4d.) for a surgery consultation and up to a maximum of \$5.00 (£2 6s. 8d.) for any other medical service where the doctor charges the most common fee. These rebates are to be based

on an agreed list of most common fees. At present the benefit societies have not published their list of most common fees, taken from patients' accounts submitted for subsidy to be paid, but have made it known that they cannot distinguish between fees paid to specialists and to G.P.s and that they consider the A.M.A.'s list to set the fees too high. The A.M.A., very sensibly, is determined to have a guarantee of regular revision of the common fees before agreeing to the new arrangements. At present the Government is insisting that medical fees remain steady so that costs are held down. Few doctors, however, are willing to accept a stationary income in a time of steady inflation and ever-rising expenses.

These changes will not alter the problems of the hospitals plagued by rising wage costs and increasing overdrafts and a rising total of road accident victims. The benefit organizations may, and usually do, refuse to pay the patient his benefits if there is any possibility of a third party paying. Thus the injured victims of road accidents find themselves faced with a large hospital bill, often only for accommodation, that they cannot hope to pay until the third party insurance settlement is reached. If there is any argument, and there usually is, this takes years. This system results in the hospitals waiting years to be paid and being left unpaid where the defendant is an uninsured man of straw. Many problems of hospital finance could be solved if the medical and hospital benefits of third-party patients were paid promptly and the benefit society reimbursed by the insurers. The wait would not hamstring the operations of the benefit societies, for they all have large and steadily growing reserves. So large are their reserves that the Australian banks have decided that they can no longer be classified as non-profit-making and have announced that they will be charged for the banking services that have hitherto been provided free.

Customer dissatisfaction with Australian medical care is mostly on the grounds of cost. If you are willing to pay, and most are, there is no waiting-list for specialist care unless one chooses a very popular doctor. Even public hospitals (free medical care) have very few on the waiting-list and medical teachers complain bitterly about the lack of clinical material. The common diseases are being treated in the private hospitals, many of them as well equipped as the public hospitals except that they have no resident medical staff. The fact that no medical benefits are payable for outpatient attendances means that it often costs the patient less to visit a specialist by appointment in his rooms and pay for it than lose a whole working day to attend the outpatient department and pay the outpatient fee, which is not subsidised.

It seems that at last the Federal Government is facing the demand for action to keep the cost of medical care within the pocket of every man. There is no indication that the Government will help finance the hospital services of the States except on an emergency propping-up basis. In both cases the government line is that the costs rise because of circumstances beyond their control—that is, doctors' fees and rising wages and costs in hospitals. As Australia has an Arbitration Court which fixes wages on the basis of the cost of living among other considerations the Government's disclaimer is hardly valid. If inflation was slowed cost rises would slow. The total for the whole of the Government's intended increase in health expenditure is less than 10% of the subsidy paid to farmers for a wheat crop which cannot be disposed of on the world market.