PERSONAL VIEW

My introduction to Australia in July 1964 started with the flaming orange, blues, greens, and purple-browns of a jet-high sunrise over Caernarvon; continued with the soft greens and greys of a damp breakfast-time in Perth; and ended with the inevitable and international jet-age wait for delayed luggage in Sydney after lunch. The sun was shining, and this was the new world of the Holden and the Gum-tree. The purpose of the trip was to study group practice and general health-care organization under the generous sponsorship of the Nuffield Foundation.

I'd learned already elsewhere on the trip that words of my own language such as "general practice," "hospital," and "National Health" didn't mean the same thing when spoken in another country, and this lesson continued in Australia. Soon after landing I also learned that it doesn't pay to have a party at the end of 7,500 miles non-stop—every face of that evening is still clear and sharp, but nothing whatsoever of what we talked about now remains.

From a few days later the words stay sharp, though some of the faces have faded—"How many caesars have your group done this year?" ; "How can you possibly call yourself a G.P. if you haven't got a hospital to work in?" ; "We had to give her four pints before I got the bleeder" ; "Would you give the pill to an unmarried girl, tell me, would you?" ; "This place cost us £16,000 four years ago, and it'll be paid off clear in another four" . . .

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General practice in Australia is certainly different from that in Britain. For a start the G.P.s earn more than the specialists. Very many premises are new and purpose-built; nearly all the groups and many of the solo G.P.s have more than one ancillary per doctor; nearly a third of the G.P.s in groups have higher degrees, and some the highest, from British or Australian universities or both; G.P.s often give total, not just primary, care. Groups can afford to overstaff with doctors, so that each member can do six months' postgraduate study every few years. I was repeatedly told that Australian G.P.s could always treat their own patients in hospital, by right. They seemed to think we never did.

This was odd, because I had been taught that "always" and "never" are two words that should not be used in Medicine. But then organization and administration are not really Medicine at all; not only in Britain do doctors tend to confuse the practice of medicine with the business of running a practice.

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The Australian patient looks the same as the British patient—at least from the doctor's chair—but he's just as different as the doctors and the practices. He enjoys the act of going to his doctor (this seems to be mutual) and he rarely asks for a house-call (visit-consultation ratios above 1 in 20 are common). He doesn't suffer the same illnesses: the hepatitis-rates may have something to do with the flies; the photodermatitis has an obvious cause; the relative lack of psychiatric illness in the eastern States may be due to pre-Balint organomaterialism; and he seldom offers his G.P. a "trivial" complaint. He even seemed to enjoy paying his bills in my presence. Pleasure in my experience is found less often in the British N.H.S., even without the bills.

The patient also pays the specialist and the hospital. An emergency appendicectomy may cost him £70 or more (no specialist necessary, all done by his G.P.s); but by the time he's taken the G.P. and hospital receipts to his insurance office, had his refund, and charged the balance to his income-tax the cost would be about £7. His premiums for this for a family of four cost 12s. 6d. a week. (Sterling equivalents in 1964.)

Hospitals are different too. Outside the university teaching

centres almost two-thirds of the beds and nearly half the hospitals are private. These and the "community" hospitals have no resident doctors, but in Queensland the State hospitals are staffed full-time, run a casualty service for anyone for any illness, and are paid for from the proceeds of a public lottery.

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I never succeeded in fully understanding the Australian National Health Service Acts (I suspect that many British doctors besides myself share a similar state of half-informedness about our National Health Service), but the principles are clear. The Commonwealth (that is, the "federal") Government pays the whole cost of health-care for two classes of patient only—those who have served in the Forces overseas, and "pensioners" (this definition includes our "chronic sick" of any age, but excludes anyone above a set income level). Everyone else must pay or be sued, but all can insure. The Commonwealth subsidizes the Benefits Funds (at the payout office), so that the insured get a refund of 80–90% of all costs—but never 100%. The philosophy is that the population must be prepared to shoulder a part of the burden, and, incidentally, to settle the bill before they get the cash. This way of working has the by-product of shifting the "inspectorate" duties off the State and on to the consumers, and the "coding" duties off the State and on to the suppliers (service-item serial-numbers must go on the patient's receipt).

Four months in Australia left me with plenty of memories: the puzzled grunts of a Hereford bull while I was photographing spoonbills in the rushes; the feel of mangrove-shoots under bare feet in the muddy sand; the sight of jacarandas against red tin roofs; and the calls of the wheeling currawongs. I never saw a Pacific or Indian Ocean surf as good as the Cornish Atlantic variety, but where else can you see an ordinary city G.P. teaching students on his own cases on the private (general-practitioner) floor of a teaching hospital, or find a G.P. who in 48 hours has resected a sigmoid volvulus, done a normal delivery and an exchange-transfusion for the infant, diagnosed ischaemic heart disease from an E.C.G. taken by himself, explained the physiology of a rare pneumoconiosis, and planned a three-week crash-programme of inoculations for foreign travel?

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Australian patients seem to like their health-care system. I met some who had been ill in Britain and were glad to be back home. The doctors certainly like it; they feel the urge to increase both the range and the quality of their service. I met more than 30 ex-N.H.S. "New Australians" who were delighted with it, though what some of the wives felt is another story. The Ministerial officials in Canberra also seemed to like it; they reckoned their system was better value for money than ours.

I don't share all these opinions myself, because a real comparison of like with like is not possible in these sort of terms. But I was convinced that in basic attitudes and in practical effects the Australian system has a great deal to commend it. After my return, and during the (surprisingly lengthy) process of rehabilitation to family, friends, and patients, I thought a lot about the problems of emigration. The man has it easy—his new work has greater challenge, wider scope, and better pay. His status in Medicine protects him from the isolation and communication-failures of crossed cultures. Homes are universal, but the place of woman in society is not. There's lots to do in Australia, but not the same things that the wives of general practitioners do here at home. Crossing cultures isolates them more than their husbands, and wives who cannot cope with this are miserable. The best time to go, I decided, was before the family is complete; roots go down as the younger children are born and grow. My youngest was coming up to O-levels—besides, I like England.

Cornwall.

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