Letter from . . . South Australia

Bright Report

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In 1972 Mr Justice Bright and his fellow committee members reviewed the health services of South Australia, recommending that there should soon be a health commission, to which would be given all health functions.¹ In essence, the idea was to give authority, responsibility, and funds to an agency and as far as possible take the provision of health care out of the political arena. Of course, it is recognised that health care is of the stuff of politics, and that governments have a special interest in this aspect of the welfare of the people, so that the health commission has to be accountable to the Minister of Health.

There is now a Bill before the State Parliament which goes some way in attempting to put into practical effect the recommendations of the Bright Report. This really was a most perceptive book and should be read by all who are interested in the organisation of health care delivery. The Bill is remarkable for its willingness to remain tentative. It specifies that the health commission shall have three full-time and five part-time members, and that they will be appointed by the State Governor on the advice of the government of the day. The object is to have three commissioners who have professional knowledge of the health service and five who represent wider interests. The commissioners will take over the existing government services and will have powers to negotiate with all other health interests, including private hospitals, most of which are heavily subsidised from taxes. But the Bill makes it very clear that when a board of management is set up for a hospital or health centre it will be given autonomy and finance for its own affairs. Even the composition of the board is to be left to its own determination, subject only to approval by the health commission. This is intended to allow for local factors always to be taken into account and for the historical backgrounds of each institution not to be cavalierly overthrown. At last it seems that a central government will be prepared to accept diversity in organisation and to trust those nearest to patients and people to be likely to know more about their needs than administrators at the centre.

Central grants

Not only is there this apparent willingness to trust boards of management but the trust will be backed with money. Grants will be given from central funds, but there will then be no detailed oversight of expenditure. It has been realised that if there is to be real administrative devolution then there must be financial devolution too. Real authority is never given without power to spend, in ways which are sensible locally and not only centrally.

The detail of the present Bill is largely taken up with safeguarding the rights of those now employed in the health services and in setting the scene for enabling legislation. Quiet evolution is being preferred to revolution, and this realism is a credit to the government and its chief officers. But there is a tiny cloud on the horizon. In a recent speech the Minister of Health for the state has said that he may set up special committees advisory to him—for example in community practice/general practice/primary care. There is no doubt about the problems in this area, but if he establishes methods of bypassing the health commission he is already negating the primacy of the concept which inspired the Bill. The health commission should be the only advisory to the Minister, whose authority he ought to uphold. The commissioners will be at least as aware as the Minister of the need for an equitable distribution of primary care.

The Bill should go through the State Parliament in about three to four months, and thereafter it is expected that it may take a year to establish the health commission. The moves all seem sensible, especially in the preparedness to move slowly on a proper time scale. No groups are to be bulldozed. Doctors, patients, nurses, and all other staff are to be consulted and persuaded into the new form of health organisation and no time limits are imposed. This is essential in a complex system where so much health care is delivered privately, mainly through insurance taken out by about 85% of the population.

Medibank, the Federal "free" system, covers everyone for 85% of the agreed private medical fees, but quite a number of doctors resent it. They are being encouraged not to charge the patient anything but to send their bills direct to Medibank. This, of course, is tantamount to accepting a 15% cut in income. It is argued by the Medibank authorities, however, that administrative expenses of the doctor will be saved in not having to send out individual bills to patients, and that the number of patients seen by the doctor may very well increase and make up his income to what it was. There is some evidence that this may be true, but it does not fully satisfy the doctors, several of whom now hand the patient a bill as he leaves the surgery so that they may save on the high postal charges. The patient then has to make an individual claim on Medibank, then add to this the extra 15% on his bill and pay the doctor.

This individual billing of the patient seems to have placed strains on the Medibank organisation, and doctors in large group practices write to the press complaining of arrears of \$100 000 over three or more months. Those doctors, however, who do "bulk bill" directly to Medibank and so do not charge the patient directly seem to be paid within a few days of the end of the month. Naturally there are suspicions that Medibank is delaying payments individually in an attempt to force those doctors who do not agree with the principles of the system to "bulk bill." Perhaps it is hoped that with inflation running at about 20% a year the loss of purchasing power of \$100 000 over 3 months may be enough to get the recalcitrant doctors to capitulate. The doctors who hand out bills to patients individually maintain that it is not the 15% cut they object to, but that they honestly believe that the doctor-patient relationship depends on the financial transaction. This ignores the fact that over

60% of the cost of health care is already paid for out of taxes in this state, and that the tax relief on medical insurance premiums is a government contribution to private health care. Most of the private hospitals also depend on government subventions. There are no absolute rights or wrongs in this state of affairs, but it does show a variety of conflicting opinions which will not easily be reconciled. The proportions of public and private health care can only be matters for negotiation, and the Bill going through Parliament recognises the fact.

Victorian problems

Against the background of South Australian attempts to solve the problems of health care delivery, the *Report of the Committee of Inquiry into Hospital and Health Services in Victoria*² is especially interesting. It has just been published and the committee consisted of only two people, Sir Colin Syme as chairman and Professor Sir Lance Townsend (other governments please note). Not surprisingly their findings were unanimous and they follow the South Australian pattern closely. It should be recognised that neither the Bright Committee nor the Syme Committee were parochial in their inquiries. They both considered very deeply the systems in Australia and abroad, so that their conclusions about the best system of organising health services in a developed country ought to be seriously heeded everywhere.

The Syme-Townsend Committee recommends the establishment of a health commission, accountable and responsible in much the same way as in South Australia. They want three full-time commissioners and four part-time ones. One of the three full-timers, it is expected, would be medically qualified and one of the part-timers a nurse. The rest should have administrative ability and knowledge and skills extending beyond the health services. A health advisory council is recommended. It would be the chief source of advice to the commission. It would have representatives from universities, other tertiary education institutions, health care professions, hospital boards of management, voluntary organisations, health workers of all kinds, and local government. It would be a large committee but would work through smaller subcommittees. The Governor in Council would make the appointments, trying to achieve a proper balance of interests. As with the Bright Report, there is a realistic, pragmatic, tentative approach which is admirable. Again time scales are elastic. There is no impatience. Stage I would hand over government services to the health commission

and thereafter it would be expected to work out solutions, not expecting uniformity everywhere.

Of special interest, in view of the tangled mess of the organisation of the NHS in London, is that the Syme-Townsend Committee found that they could not as yet make helpful recommendations about metropolitan Melbourne. This is a big city with a population nearing 2½ million. Its health services and hospitals have grown up without regard to present day problems. The committee therefore recommends that the easier problems of the country areas should be worked out and that those of Melbourne should be a call on the health commission early in its life. There is here the recognition that provinces and metropolis are essentially different and that the pattern for one cannot be the blueprint for the other.

The costs of introducing such a new system will be great. In Victoria many hospital services are given by doctors on an honorary basis. These proposals will mean that they will have to be paid. Moreover the committee sees no end to increased sophistication and demands for medical care. Already 76% of the cost of hospitals is accounted for by staff salaries. "We sense a public expectation that every citizen who suffers from ill-health should, without regard to cost, be entitled to the highest quality of curative treatment which current technology can provide". The proportion of total state government expenditure which went on health was 16.5% in 1973-4, and if present trends continue then medical and health care will take 21% of total state expenditure by 1984-5.

The obvious conclusions are drawn that either State revenues must rise, other services will have to be reduced, or the rate of growth of health services will have to be curbed. Sometime, somewhere, somebody is going to have to decide whether medicine and health care have prescriptive rights to continue to expand. If the limits are imposed then who will pay the bill in suffering, disease, and death? Society and the doctors do not yet seem prepared to answer these very awkward questions. Their relevance daily becomes more apparent. The health commissions may have the beginnings of a chance to answer them and may provide good advice to the ailing NHS in Britain.

References

- ¹ *Report of the Committee of Enquiry into Health Services in South Australia*. Adelaide, Department of Public Health, 1973.
- ² *Report of the Committee of Enquiry into Hospital and Health Services in Victoria*. Melbourne, Department of Health, 1975.

What is the value of under-the-tongue testing for allergens?

I don't think under-the-tongue testing for allergy has been carried out on a wide enough scale to know. It would, however, seem a logical extension of testing for bronchial sensitivity by inhalation of allergens, and might be explored in a search for food allergies.

What is the most effective source of fibre in the diet and how much should be taken?

High residue diets for prophylaxis and treatment are very fashionable, but the evidence is mainly epidemiological and inferential.¹ The evangelistic approach has the virtue of simplicity but obscures the difficulties about the definition of residue and its method of action. Even discussing fibre is a form of mental shorthand because we do not know which element in the diet we are trying to increase. Crude fibre remains after acid alkali hydrolysis of vegetable and in wheat bran is about 4% of the total. Southgate determined unavailable carbohydrates, and bran contained 30-35%.² Certainly only a little of this is fibrous and it consists of a complex mixture of carbohydrates and a little lignin. I find that if a high residue diet is constructed without using bran, it is either very expensive or dull. The easiest way is for the patient to take 15 g of bran a day or more. In Britain processed bran

is easily available and all forms are roughly equivalent. It is best taken as a breakfast cereal, and a commercially available bran crispbread is also useful as a palatable alternative. The dose is 6 crispbread a day. Isogel, methylcellulose, Normacol, Celevac, and Fybogel exist as bulking agents and are particularly useful for the patient who is impressed by the prescription pad. All-Bran, however, contains maltose, which is laxative in its own right, and is not simply a residue-producing agent. Prospective experimental evidence exists only for the spastic colon/diverticular disease syndrome.³⁻⁵ Several trials support a dose of 15 g of wheat bran a day or more with symptoms relieved in 60-70% of patients but another trial showed absolutely no relief. High residue diets for other diseases remain unproved. Bran is not hypocholesterolaemic. A high residue diet is most easily constructed by adding three heaped tablespoonfuls of bran a day to the normal diet. This regimen is useful in managing the spastic colon/diverticular disease syndrome and some cases of constipation. Other bulking agents may be used quite satisfactorily but are vastly more expensive.

¹ Painter, N S, and Burkitt, D P, *British Medical Journal*, 1971, **2**, 450.

² Southgate, D A T, *Journal of the Science of Food and Agriculture*, 1969, **20**, 326.

³ Painter, N S, Almeida, A Z, and Colebourne, K W, *British Medical Journal*, 1972, **2**, 139.

⁴ Plumley, P F, and Francis, B, *Journal of the American Dietetic Association*, 1973, **63**, 127.

⁵ Brodribb, A J M, and Humphreys, D M, *British Medical Journal*, 1976, **1**, 424.