Letter from . . . Brisbane

Day nurseries and welfare states

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British Medical Journal, 1976, 1, 1523-1524

"That vast day nursery, the welfare state!" For the expression I am indebted to Professor Sir Sydney Sunderland, a most distinguished Australian academic, and a very good description it is of the sort of society that could develop in Australia. Welfare can mean different things to different people; in the national sense, it should imply that society is prepared to help those who are not equipped to fend for themselves. How many such people are there? Are they a small minority, a large minority, or a majority? If a small minority, to what extent should social policies aimed at helping them entangle the majority in processes that, in the long run, could have an adverse effect on the community as a whole?

We hear a lot these days about the barefoot doctors of China, the medical auxiliaries of Africa, and the traditional medicines of South-east Asia. No doubt they contribute a great deal to the people they serve. But as a member of a visiting delegation from Peking said to a friend of mine who was entertaining him here, the present Chinese way of life is very good—for China! It seems fair to say that social customs suited to a community emerging from a state of widespread poverty and illiteracy, with an undeveloped industrial base, are not necessarily applicable to a different community, with a long history of literacy, a generally prosperous community, high living standards, and modern industry.

Free-enterprise society

In politics, left is left and right is right and never the twain shall meet. In the Australian Federal and six State parliaments only one communist has ever won a seat. There have been more years of Federal Liberal-Country Party (conservative) than Labour governments, and last December the Whitlam Labour government suffered a stunning defeat. The majority of Australians most of the time support a right-of-centre government and a free-enterprise type of society. If the citizen of this type of society wishes to be free to decide how he will live and work, how he will speak, assemble, worship, and take holidays, he should also accept certain responsibilities. He will have to provide himself and his family with food, clothing, and accommodation, should insure his life and property, keep himself informed by the media, pay his taxes, and, in Australia, vote (compulsorily) in elections. Most people take holidays, and some, even now, save for their old age. Many invest large sums in tobacco, alcohol, and the various forms of licensed gambling such as horse racing and lotteries. At times he will need the aid of pro-

fessional people such as accountants, architects, bank managers, and lawyers, for whose services he can expect to pay, but who, despite this, may even become his friends.

Dual systems of health care

Against this background, to what extent should John and Mary Citizen be expected to pay directly at least a part of the cost of their own health care? Many family medical needs are predictable. Antenatal care, confinements, neonatal attention, immunisation, minor childhood ailments, simple fractures, appendicectomy, and, later, treatment of hypertension, coronary artery diseases, bronchitis, and management of the menopause, these are likely needs of an average family, the cost of which would be a small fraction of their expenditure on, for instance, food. The State does not supply free food and housing: why then expect it to supply free medical attention for non-life-threatening and non-urgent conditions, which are largely predictable and, item by item, not unduly expensive?

Rudolf Klein (*BMJ*, 6 December, p 591) states that it is unthinkable that some people should get better medical care than others. In effect, he takes both sides of the debate about private practice in Britain and as adjudicator awards himself a tie. He justifies private practice by saying that the citizen needs an alternative service to which to turn, but limits it by refusing to let it detract from the public sector by withdrawing scarce services. Very good in theory, but here in Queensland we have had a dual system for about 40 years—a free public hospital system whose "casualty" departments are in effect vast general practice clinics open to the public without means test, peacefully coexisting with private general and specialist practice. Large private hospitals and intermediate—that is, pay bed—sections of public hospitals supplement public hospital beds. Most psychiatric beds are public, but even in this field two excellent private psychiatric hospitals have recently been built here, primarily as a result of the efforts of psychiatrists themselves; indeed, one provides the only beds for mental illness available on the south side of Brisbane, where half the city's population lives. As before the introduction of Medibank about half the population were insured under Medical Benefits Schemes (the figures were nearer 80% in the southern states where entry to public hospitals was restricted by a means test), it is likely that half the population attended private practitioners. It may surprise Rudolf Klein that a public service could function in the face of such competition, but the distribution of doctors between private and public sectors has kept parallel with the demand for their services—though, to fill some positions, officers of the State Health Department make regular recruiting trips to Britain.

State aid for education

Mr Klein also points to the similarities between dual systems of health care and dual education systems. Parallel educational

systems exist in Australia, too. One of our perennial arguments revolves around State aid for education. Those opposed to it say that not a penny of State money should be spent on subsidies for private schools. At the other extreme are those who say that all children have an equal right to State support for education, that all children should receive equal financial assistance from the State, and that those parents who wish to supplement this by private spending should be free to do so. Both cases may be supported by irrefutable arguments; strong passions are aroused on both sides, but the adjudicator is our old friend the ballot box.

State aid for education comes primarily from the Federal government, and a party that proposed to abolish State aid could expect to be defeated at the first available election. A compromise has been reached in which all independent schools get some State aid according to a formula that gives an estimate of the "need" of each particular school, the intention being to upgrade the less-well-equipped schools to a minimum acceptable level. Even the most lavishly equipped schools get something, so that the government cannot be accused of favouring those who did not endeavour to help themselves while at the same time discouraging those who have made efforts on their own behalf. Questions concerning State aid go further than this but are seldom discussed publicly. Clearly, a central bureaucratic State agency should not lay down curricula and standards for all schools. Experience in Australia suggests that such an arrangement would inhibit that freedom of innovation that is essential if education is to keep pace with developments and changes in society. Equally, it seems most unlikely that the nation will ever be wealthy enough to provide absolutely first-class facilities for every schoolchild. Would anyone be so bold as to say that until every child can have first-class facilities no child must be allowed to enjoy them? To deny this right would be the height of folly and the worst possible example of levelling down. Further, the best schools give the less good schools something to aim at, while at the same time they have an obligation to maintain their own standards. Would Rudolf Klein accept the same argument about medical services? If, for instance, it is necessary for most people to wait three weeks for an outpatient appointment, must nobody be seen promptly or at a time of convenience?

Personal responsibility

In some parts of Australia, Medibank has increased the drift of patients into the private sector of medical care. Professor

Maddison, dean of the new Faculty of Medicine in the University of Newcastle, Australia, talks of the "virtual collapse" of some outpatient clinics and the effect of this on teaching medical students. He states, "a properly organised outpatient service, on a type of polyclinic basis . . . could begin to move us to the provision of appropriately comprehensive care for total populations, rather than the intermittent care of illness episodes which is the outstanding feature of the private sector's contribution." Yet surely in the lives of most of us, illness is intermittent, with long periods of normal health when no assistance is necessary, intermittent medical attention being the correct treatment for intermittent illness. Only a minority have severe, chronic, or repeatedly relapsing illness causing inability to work or needing permanent care. Listening to some academics and bureaucrats, one gets the impression that the whole population is made up of indigent chronically ill people bordering on mental deficiency who cannot be trusted to manage their own affairs, but who must be constantly shepherded through the cubicles of community service centres staffed by doctors and paramedics of saintly personality, who have frequent meetings to discuss the needs of their "clients" and dispense carefully measured parcels of therapeutic substances, counselling and happiness, in a warm, supportive atmosphere. So we retreat steadily from the old work ethic, with promotion of a take all, give little spirit, a smaller real margin for training and responsibility, disincentives to farmers (in Australia the new poor), discouragement of the entrepreneurial spirit by punitive taxation, and now the provision of "day nurseries" for John and Mary Citizen and their children without regard for the possibility that they may be able to look after themselves.

Is democracy too difficult for us? Acceptance of its advantages and freedoms demands equally ready acceptance of its responsibilities. Politicians who buy popularity, bureaucrats who seek power and personal advancement rather than opportunities to serve, a public that accepts direction because it does not want to make trouble, a widespread disinclination to risk unpopularity by standing up to be counted, all bode ill for the future of the Western world. Solzhenitsyn, who learnt political science in a hard school, has warned us of looming danger.

Welfare in the best sense of the word is one of the most desirable attributes of a modern state. When will our leaders learn that welfare costs money and that money comes from production? When will our medical policy planners wake up to the probability that the "day nursery" mentality, by encouraging the citizen to look to the State as a crutch and to avoid accepting a measure of responsibility for himself, may ultimately threaten the future not only of welfare but of the State itself?

What is the rationale behind combining vitamin A and calcium carbonate as prophylaxis against sunburn? Is this treatment considered effective?

Vitamin A has been prescribed to protect the human skin from exposure to sunshine. The treatment was based on the idea that excessive solar irradiation produced excessive vitamin D in the skin and that vitamin A could counteract this effect. In addition, a skin deficient in vitamin A could be abnormal in that it would appear dry and dystrophic. The reason for combining with calcium carbonate is not clear. Vitamin A may be administered by mouth in a daily dose of 50 000 to 100 000 IU for a maximum period of 14 days, and in an uncontrolled trial was reported as reducing the unpleasant sequelae of solar radiation.¹ Nevertheless, controlled double-blind trials have not shown any protective action against solar irradiation by vitamin A with or without calcium carbonate.^{2,3} Although the proposed treatment regimen spread over 14 days is safe and unlikely to do harm, there is as yet no acceptable evidence other than subjective impressions that vitamin A would allow anyone going on holiday to avoid the reliable method of gradual planned exposure to sunshine aided by the correct use of light-screening preparations.

Is Marplan an addictive drug and should it be avoided during pregnancy?

Isocarboxazid (Marplan) is not addictive. Once an appropriate therapeutic dose has been found for each patient it is never necessary to increase the dose to control the symptoms, however long it is used. Premature or sudden withdrawal in depressive illness or anxiety leads to recrudescence of the earlier symptoms, indicating a medical need. If the drug is required for treating these conditions over a long period a search should be made for factors which can perpetuate the illnesses such as unexpressed grief, the premenstrual syndrome, and the concurrent use of analgesics or barbiturates. At present there is no evidence to indicate that isocarboxazid is a teratogen, but its use during pregnancy is best avoided for the following reasons: (a) many drugs used in managing labour or abortion are incompatible; (b) the symptoms of depressive illness or neurosis usually improve and often resolve completely during pregnancy; and (c) many mothers, acutely sensitive that drugs may affect the fetus, become more anxious despite reassurance to the contrary. In practice, it is best to confine this drug or other monoamine oxidase inhibitors during pregnancy to those patients for whom no other form of management is satisfactory, when the risks of harm to the mother far outweigh those from using the drug. It should be avoided during the first trimester, unless absolutely necessary.

¹ Turner, A C, Barnes, R M, and Green, R L, *Practitioner*, 1971, **206**, 662.

² Anderson, F E, *Australian Journal of Dermatology*, 1969, **10**, 26.

³ Furman, K I, *South African Medical Journal*, 1972, **46**, 1670.