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BARTS MEDICAL SCHOOL – REQUIRED REPORT ON SCHOOL APPROVED OBJECTIVES-1150 words

1. What are the prevalent paediatric conditions in Australia? How do these compare with the UK?

Both the UK and Australia are developed nations. Comparatively Australia has a slightly higher proportion of children at approximately 20% of the population compared to about 17% in the UK. In both countries a common childhood disease is Asthma with one in four Australian children experiencing one asthma attack per year. As with the UK, asthma as a condition of atopic individuals means that other atopic conditions such as eczema and allergic rhinitis are also common in children in Australia. Childhood obesity is an increasing problem in both Australia and the UK and both departments of health have produced advice to try and combat this issue. Death from accident is the most common cause of childhood death in both countries. Cancer is also relatively common in both countries, typically haematological. In both countries treatment is often successful. ENT conditions are prevalent, most commonly otitis media or tonsillitis. The insertion of grommets, small tubes to relieve middle ear effusion, is a common surgical procedure in the UK and Australia. Both countries have moved away from the traditional early surgical approach to recurrent tonsillitis and now reserve surgery where tonsillitis is occurring extremely frequently.

In both countries there is an extensive program of immunisations, starting at or close to birth to prevent many childhood diseases through direct or herd immunity. The schedule and diseases vaccinated against are broadly similar however Australia additionally vaccinates children at birth against hepatitis B and at 18 months against Varicella Zoster (VZV or 'Chicken Pox'). The UK only vaccinates at risk groups for hepatitis B, such as healthcare workers, and chicken pox is a common childhood illness. The rationale for not vaccinating against VZV in the UK is derived from the perceived low benefit to cost ratio.

2. How are paediatric services organised and delivered in Australia compared to the UK?

Australia runs a dual system of public and private healthcare services as does the UK, however public healthcare is funded in part through direct taxation for health rather than general taxation measures as in the UK. This levy supports the Medicare system (public healthcare). However, additional costs are not covered through Medicare and must be paid directly by the patient. This is similar to the UK where things like dental treatment are subsided but not necessarily free at the point of access except in children and low income groups. Private health insurance may cover this in both countries. The Australian government encourages the uptake of private health insurance by additional levies on higher earning individuals who do not take out insurance.

Australians access paediatric care through primary and secondary care. Paediatricians can be accessed via primary/secondary care referral or directly through private healthcare as in the UK. Most hospitals have some paediatric services but in addition there are more specialist facilities distributed regionally which children can be referred to either through primary care or by direct referral from another paediatrician.

3. Does health provision differ between the town and rural setting and what measures exist to support rural and remote access to health?

Australia has a much bigger land mass than the UK and the smaller population is spread across vast distances. While it is true that the majority of people are concentrated in or around cities, predominantly in

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the coastal areas, around a third of the population are classified as living outside a major population centre. Up to approximately 12% of Australians can be classified as living in the outer-regions, remote or very remote areas. As distance from major population centres increases, so does the proportion of inhabitants from the native peoples, with indigenous people making up 45% of inhabitants in very remote areas. Both life in rural areas and indigenous heritage are linked with higher incidence of chronic heart and lung disease, diabetes and lower life expectancy compared to the urban population. Lower life expectancy, in part, also results from generally more hazardous living with higher rates of smoking and alcohol use as well as a higher frequency of accidents and more perilous environments.

Factoring in both the enhanced health needs and the large distances between sparsely populated areas it is clear that the health model is Australia outside of cities is very different to that seen in the UK. Several outreach programs exist to serve the rural parts of the country. Of these the most well-known is likely to be the Royal Flying Doctors Service which not only provides emergency care but is also a big primary care provider in remote communities through clinics and telecare consultations. In addition to this service a dedicated female GP service exists to provide care to women, specialist clinic outreach and visiting dental and ophthalmic practitioners.

4. Reflect on how medical training differs between the UK and Australia including widening access from more disadvantaged backgrounds?

Undergraduate medical training is broadly similar between the UK and Australia with two main routes into training – straight from secondary level education to follow a 5-6 year curriculum or a 4 year graduate entry program following any batchelor's level qualification. Australia has 18 medical schools for a population of about 22 million compared to the UK which has 33 medical schools for a population of approximately 3 times the size at 63 million. Both countries have a tradition of encouraging and supporting students from more disadvantaged backgrounds to study medicine. In the UK schemes such as medical schools supporting local school children in lower achieving schools, access courses to medicine and medical courses with a foundation year all contribute to allowing students who may not have had the best opportunity at school to study medicine. In Australia, schemes exist to encourage students from backgrounds without a tradition of higher education such as the native Aboriginal population to enter medical training. In addition, there is a specific scheme in place to recruit students who will go on to become part of the rural and remote health network – a vital part of Australia's healthcare network. This program takes 300 medical students per year and organises remote and rural placements for them. The aim of the program is to demonstrate the opportunity that exists in rural remote healthcare and encourage new doctors to consider a career in this area.

Financial burdens still are a significant barrier to entering higher education. In the UK the introduction of much higher tuition fees is likely to more negatively affect those from low income backgrounds. In Australia, undergraduates have much of their fees subsidised by the government in a scheme similar to how the UK used to operate. This empowers students from low income backgrounds to enter university. This is something that is close to my heart as I am from a low income background myself and I am concerned at the direction the UK has taken, possibly restricting access to higher education on the basis of income.

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