

South Africa vs. Australia - What is the Score?

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Abstract

This paper looks at general practice in Australia from a South African's perspective. It focuses on some of the advantages and disadvantages of the National Health Insurance Scheme, which is the cornerstone of

health care in Australia. Other issues discussed are the status of general practice, general practice training, the role of hospitals, and the Aboriginal Health Service.

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Introduction

I was fortunate to spend the first 6 months of 1998 on sabbatical in Australia, working at the Monash University Centre for Rural Health, in Moe, Victoria, a town of about 26 000 people 2 hours east of Melbourne. The Director, Professor Roger Strasser, is a leading figure in General Practice in Australia. Issues surrounding general practice were constantly debated in the Centre, through the involvement of staff members in different projects and committees, and through visitors who came to the Centre. I was able to attend a number of workshops and conferences with GP's, GP trainees and GP trainers around the country. I also did a weekly clinical session at the Moe Medical Centre as a general practitioner. This gave me the perspective of working within the system and put me in touch with the views of doctors at the coalface. This paper is an attempt to draw together some of the things I learnt about general practice in Australia, which

may be relevant to our evolving situation in South Africa.

National Health Insurance Scheme (Medicare)

The system of universal Health Insurance in Australia seems, at first look, to be an ideal to be striven for. The Federally funded Health Insurance Commission (HIC) provides access to medical services for all who need it through the Medicare system. This is a publicly funded fee-for-service system. A person wishing to see any GP simply makes an appointment, and on arrival presents their Medicare card, which then entitles them to free treatment. The practice gets the patient to sign a form and submits a claim to the H.I.C. office in the particular State, which then guarantees payment, thus minimising the problem of bad debt. Should the patient need a prescription, the GP will prescribe items on the National Pharmaceutical

Benefit Scheme and the patient can get almost anything he or she requires for \$3 per prescription. Medicare pays for any investigations. Should a patient need admission to hospital, Medicare will pay. Specialist consultations are also paid for, as long as there is a GP referral. The GP plays the gatekeeper and co-ordinator. Patients are happy, doctors are happy, everyone is happy....

Well, not quite! If we scratch a little below the surface, there are a number of problems. I will mention a few to illustrate the point.

The federal government is not happy. It is spending too much on Health Care. A number of years ago it decided to try to cap expenditure on Medicare, and payments to doctors were fixed. Thus for 5 years until 1998, the normal consultation (up to 20 minutes) for a vocationally registered GP was limited to \$24 (about R92), or \$16 (about R60) if

you are not vocationally registered. For many doctors this is not enough so they charge higher than Medicare rates. The rules say you can then no longer submit your claims directly to the Commission, but must charge the patient, who can then claim a portion from Medicare – enter bad debts and late payments! In wealthier areas people may have private health insurance – and even the Health Insurance Commission itself sells this – but in working class and rural areas, such as where I worked, this is rare, and people resent having to pay for their health care. Furthermore the regulations forbid top-up health insurance, i.e. insurance to cover the difference between Medicare rates and private fees: patients who have private health insurance cannot claim anything from Medicare. A case could be made that Australian GP's should be happy with what they get, because even charging Medicare rates only (as the practice I worked in did), one can make a decent living. However, at night, doctors can only charge overtime rates for the first call out during the night, but have to charge daytime rates for any following consultations – the theory being, it seems, that you are up anyway.

Then there are the patients who need allied health services. For example, you see a patient with a back strain who you want to refer to a physiotherapist. You can send the patient to the hospital where the physiotherapist is, and he or she will be given an appointment for anything up to 2 weeks time – when the problem is over. You can of course send her to a private physiotherapist, but that is not covered by Medicare. What about Occupational Therapy for a Cerebral Palsy child? In the Moe area, a baby getting intensive treatment was being seen once every 2 weeks!

Similarly, if you want dental work you have to be very patient and have a high pain threshold – or enough money to pay for a private dentist: again Medicare does not cover that.

In contrast, you can go to your GP as often as you like. More significantly you can go to a different GP every day of the week! Doctor shopping is thus a major problem. If you are not better the day after you have seen me, you go to my colleague down the road, and the day after to our colleague in the next suburb or town. Medicare pays.

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Although there are some attempts now to prevent doctor shopping using prescriptions, which are all entered on to computer, a clever patient can use different pharmacies, and the central computers only flag patients with more than 50 prescribed items in a month!

Then there is the problem of marginalised immigrant communities and aboriginal communities, who have not entered into the culture of visiting their doctors at the drop of a hat. Although health education is excellent and patients are generally very well informed, this does not always reach disadvantaged communities. How does one ensure screening programmes are implemented? How does one ensure

immunisation? The key primary care giver, the GP, does not provide health care for a particular population, but only for those who walk through his or her door.

The government is trying to deal with this. They have introduced incentives, such as bonus payments to practices that immunise a certain percentage of the children they see, and other rewards for screening programmes are being introduced. One way around this would be to introduce some sort of capitation funding alongside the fee-for-service, linking populations to practices. However, this would bring the government into direct conflict with another Australian phenomenon, the Consumer Movement. The Consumers Health Forum – whose members adamantly proclaim themselves as consumers and not patients – decries any consideration of such linkage as conscription, and has vowed to fight it resolutely, a threat Australian politicians take so seriously that the 1998 GP

Strategy Review did not even raise the possibility.

The status of general practice

Mention of this review leads me on to the status of General Practice as a profession in Australia. I have already mentioned the gatekeeper role of the GP. General practitioners are seen to be the key players in the health service who co-ordinate the provision of services and provide primary care. The Federal Government listens to what GP's have to say and even requests their input. While I was there, 2 federally funded commissions, consisting almost entirely of GP's, delivered their reports, viz. the General

Practice Strategy Review and the General Practice Training Review. It is exciting to see General Practice as a discipline being acknowledged in such a way.

At the same time arrogance and lack of teamwork is threatening this access to the corridors of power, and people within the profession are sounding warning bells. We can learn from that, and make sure that attempts to improve our status and standing are not at the detriment of other health professionals.

General practice training

General practice training, as alluded to, is another area in which the federal government has significant financial input. The entire training programme of the Royal Australian College of General Practitioners (RACGP) is federally funded, because the Health Department recognised the need for GP's to be well trained, in the light of their pivotal role. The RACGP runs a 3-year vocational training programme in each State, which is both hospital and practice based, leading to the Fellowship of the College. This is now the only route to entering general practice, except for locum work and work in underserved areas. The key principle, which impressed me, is that general practice education is firmly and unalterably in the hands of general practitioners. (This will be discussed in a further article.)

The monopoly that the RACGP has on GP vocational training, as distinct from academic family medicine, where all the medical schools are involved, is about to end. A few years ago frustrations amongst rural doctors, who thought that the training programme did not equip GP's for rural practice and that it was biased

in its education and its examination towards urban practice, reached a head. Thus the Australian College of Rural and Remote Medicine was born. The GP Training Review has now recommended the establishment of a separate training board, which will function as an independent arbiter to regulate training and dispense funds. This has since been established, and changes are presently being implemented.

Hospitals

Hospitals are run by State Health Departments, which are constantly battling with the Federal Government for more money. Previously nearly every small town had a hospital, with GP's running the Emergency departments and having admitting privileges. Bigger towns have full-time resident medical officers and specialist staff as well, and many of the larger hospitals have satellite status for registrar training. Many of the resident medical officers are either GP registrars doing their so-called hospital terms as part of their vocational training, or foreign doctors with limited registration for hospital practice. Patients seen in the Emergency Department, or admitted, are usually referred on to the GP of their choice, and there is generally a fairly good relationship between local GP's and the hospital.

The big change that has been happening over the last few years is that, in order to cut costs; the State Government is closing small hospitals, expecting patients to travel further to regional hospitals. For example, in Moe, the Hospital closed a few weeks after

I left and a new regional hospital opened 30 km away. This places a lot more stress on the local GP's who have to deal with problems that should be seen in Accident and Emergency Departments. Furthermore, many small towns have lost their GP's because they are frustrated with the loss of skills that the closure of the hospital has meant to them. This counteracts the rural incentive schemes! (A third article will discuss issues related to rural practice in Australia)

Aboriginal Health Service

Alongside all this there is a separate stream, the Aboriginal Health Services. Indigenous people have free access to general practices and to the hospitals, but there are also government-funded centres, often community controlled, which cater specifically to the health needs of Aboriginal people. I struggled to understand the concept of Aboriginal Health as a separate entity: it seemed like something that came out of the old South Africa. However, Aboriginal activists say that, given the fact that they are such a minority (under 1% of the population) and that their health status is so poor in comparison to so-called white Australia, this kind of separate strategy, or affirmative action, is necessary. Special attention is given to major health problems like diabetes mellitus, hypertension, cardiovascular disease and alcoholism. It also allows for culturally appropriate responses to problems of Aboriginal Health. Most of these Health Centres have Aboriginal Health Workers who function as mediators between doctors and patients, or, in the case of the outback, between nurse practitioners and patients.

Conclusion

So what is the score? Australia has gone out to bat first and has amassed a huge total. But the Australian defence is not

without its weaknesses, which might cause its downfall in the second innings. We have a development team

with great potential, which may yet turn in a creditable performance with the right coaching and the right sponsorship.