Australia – being there (in praise of general practice)

Alcuin Wilkie

"... the cardinal requirement for the improvement of the mental health services in this country, is ... a strengthening of the family doctor in his therapeutic role." – Michael Shepherd (1966).

To the uninitiated it may seem logical that the whole point of going from the UK to work in another developed country is to learn about new techniques and different systems and to bring that experience back to enrich and improve clinical practice at home (and meanwhile have a holiday into the bargain). That is not quite how it works though – what you really learn are the merits and deficits of those aspects of practice in your own country which you had never really thought about and taken more or less for granted.

Having experienced being a psychiatrist in Australia for a year, I have returned not with innovative ideas on changing psychiatric practice, but with the revelation that the most precious component of our National Health Service is the primary care system. This was not a sudden revelation but the end product of numerous instances when I had such thoughts as: "if this person had a GP I wouldn't be seeing them"; or "I wish I could 'phone up this patient's GP and find out what was happening to her five years ago"; or "I'll just get in touch with this one's GP and ask him to keep an eye on things". My feelings and thoughts about the innate effectiveness and efficiency of the primary health care system in the UK were confirmed by my wife's account of her work in the accident and emergency department of one of Sydney's most deprived suburbs and through conversations with colleagues who had also worked in both systems.

The primary health care systems in Australia and the UK differ in several fundamental aspects. Although both countries have a comprehensive public health care system funded through centralised taxation, in Australia GPs work entirely as free agents and are paid a standard fee for patient consultation by "Medicare" – the Federal Health Insurance Fund. The GP may charge the patient more than the standard Medicare fee with the patient making up the difference either in cash or from their own private health insurance. In the UK, GPs are not paid for each consultation but receive a "capitation fee" from the Family Health Services Authority (FHSA) for having patients on their list whether they see them or not.

In Australia patients have no exclusive relationship with GPs and can "doctorshop" – seeing a different GP each day of the week in a completely different part of town – whereas in the UK patients have their "own" GP with whom they sign on and, apart from his colleagues, they will only be seen by other GPs in exceptional circumstances. Partly because patients do not sign on with a GP, there is no centralised primary care health record in Australia, unlike the primary health care record which follows our patients from birth to death. Each GP keeps their own notes which do not move with the patient. In addition there is no requirement for formalised GP training prior to setting up independently as a GP – it is possible to go straight from a period of supervised intern training to working as a GP.

A further fundamental difference is that as well as visiting different GPs at will, Australians can also visit "Medical Centres" – these are walk in shop fronts often situated in shopping malls, which offer primary health care consultations and are staffed by doctors employed on a sessional basis – the ethos is that of a shop and the doctor/patient relationship is perverted into a customer/shop assistant relationship. Due to the changing nature of the doctor/patient relationship, investigations, blood tests, X-rays, CT scans, ultrasounds and medication are of paramount importance, and in close proximity to the medical centres and surgeries in each shopping mall there is an array of radiology suites, chemical pathology laboratories, and pharmacies.

These differences in the two health care systems cause doctors and patients to play markedly different roles. In Britain, a GP would have a relaxed and wealthy life style if he had a large number of healthy patients on his list, who almost never come and see him except for old age health screening, cervical smears, family planning and minor surgery. If he is a fundholder, holding the budget for his patients' health care, his practice will benefit financially with the fewer referrals he makes to hospital specialists. Furthermore, if none of his patients ever came

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to see him he would make a very pleasant living. In Australia and presumably most of the rest of the world a GP who saw no patients would earn nothing. The way for an Australian GP to earn money is by having as many patient contacts as possible, each as short as possible. I use the words patient contacts because there is a financial incentive in the system to see the same patient frequently – instead of the British GP's dictum "come back and see me in 2 weeks if it doesn't get better"; an Australian GP might say "come back in a week and I'll see how you are doing". The point at which the doctor's attention and caring solicitude becomes fraudulent – what the Australian authorities are investigating as "over servicing" – is debatable. The same Australian GP has less financial incentive to try and prevent illness than to investigate it and treat it and when faced by patients with chronic and complicated medical and social problems, likely to require liaison with different agencies, he will be happy to refer them on, as soon as possible to the appropriate hospital specialist. Whereas for a GP in the UK having patients on their list invokes responsibility to manage these problems in conjunction with the appropriate hospital specialist. It was my experience in psychiatry that I cared for patients in out-patients whom in the UK I would never or rarely see because they would be managed by their GP. An English colleague who worked in old age medicine in Sydney had the experience that a high proportion of his time was spent in routine and basic assessment of physical and social problems which in the UK would be investigated and managed by GPs.

Due to the less than pivotal role of the Australian GP in patient care and the lack of a centralised primary health care record, I found there was less tendency for hospital doctors to communicate with GPs than in the UK, in terms of both receiving and giving information. In Australia the patients whom one would most like to be able to get accurate information about are those who are less likely to attend one GP regularly rather then to shop around. These are the patients whose histories and complaints do not quite ring true; the patients with complex family and social problems; or the patients with unexplained physical symptoms despite numerous investigations and procedures. Conversely, as there is no one person responsible for the health care of a patient outside hospital in Australia, there is often little point in the hospital doctor contacting a GP, particularly if the patient has self-presented at an accident and emergency department or has been referred by a medical centre – a good example of this is the case of a patient who has taken an impulsive overdose and is judged to be medically fit and no longer depressed or suicidal but whose life problems still exist.

I found that behaviour of patients in Australia was rather different from that in the UK, they tended to see GPs as the source of a service or product that they wanted – investigations and medication – rather than seeing their GP as a person with whom they could develop a trusting relationship. If they did not get the service they wanted they would frequently go elsewhere. In the accident and emergency department my wife saw a patient with a handful of different prescriptions from different doctors written over two days, who wanted a final opinion on which was the best to take. Investigations were often invested with a therapeutic value and I spoke to a relatives group who could name every cardiac investigation including echocardiography and cardiac catheterisation but were not able to put forward smoking as a cause of heart disease. Unfortunately, patients who misused habit forming prescription pain killers and tranquillisers, although not encouraged by the primary health care system in Australia were able to obtain constant supplies of these by shopping around.

Comparing Australia and the UK, I realise I feel at home in England, the UK and Europe – in that order – but there are only three things about the UK that I unreservedly feel good about: its inhabitants' ability to laugh at themselves (and everyone else); a police force that do not routinely carry guns (except in Northern Ireland); and, our primary health care system. Ten years ago I would have said I feel good about the National Health Service, however, with the transformation of all health authorities and hospitals into disparate trusts and purchasers, it is difficult as a hospital doctor to feel part of a unified national health service and I fear that in the same way that we refer to "The Former Yugoslavia" we will soon be talking about "the former National Health Service". Although successive governments seem to see the current primary health care system as a good thing, I have a nagging worry that somewhere a green paper is being drawn up with the title "Putting Patients First – a Strategy for Primary Health Care". This green paper will outline the government's plans to dismantle the current system and replace it with a fee per visit system together with a large administrative buraucracy which will dispense the fees. If so, I have seen the future and I don't like it.

Reference

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