Family Practice — World Perspective

The Role Of The General Practitioner In The Australian Health Care System: Lessons For US Family Physicians

Thomas L. Schwenk, MD

The Australian health care system and the role of its general practitioners are often mentioned in discussions of health care reform in the United States. Because of Australia's original membership in the English Commonwealth (a relationship that is currently being debated with great vigor in Australia), its health care system resembles that of England in certain regards, particularly its single-payer, publicly funded foundation and the proportion of its physicians who are general practitioners. Post-World War II American influences, however, have affected the Australian system as well, particularly the prominent role played by subspecialists in the private health care system that operates in parallel with the public system.

I had the opportunity recently to study the status of general practice in Australia, primarily through meetings with the heads of general practice at the University of Melbourne and Monash University in Melbourne, a review of a series of recent government reports addressing the status of general practice in Australia, and the experience of living in Australia during a 5-week federal election campaign in early 1993, in which public opinion about health care was a critical determinant of the election outcome.[1] Based on these data sources, several interesting contrasts can be drawn between the health care systems of Australia and the US, with some implications for US family physicians.

Structure of the Australian Health Care System

Australia is one of the most highly urbanized, yet least densely populated, countries in the world. Its population of 17 million is roughly equal to that of New York or Texas in a country the geographic size of the US, while 85 percent of the total population lives in a metropolitan area. This population density is about that of the state of Montana, whereas its urbanization exceeds that of Japan. The Labor government introduced the current system of publicly funded health care (called Medicare) in 1984, when it came to power. The system has continued under the Labor government's subsequent electoral success, including its most recent parliamentary victory in March 1993. One of the most important election issues was whether the health care system would remain public with only limited private supplementation, or whether the private system would be subsidized more extensively through tax credits for private health insurance, so as to reduce pressure on the overloaded public system.[1]

Certain fundamental principles of the Australian system are critical to the role of the general practitioner. The system is basically a publicly funded system of private and public physicians and hospitals, somewhat like having American and English systems operating in parallel.[2] In 1990 approximately 8 percent of the gross domestic product was spent on health care in Australia, compared with 12.4 percent of the gross domestic product for the US in 1990,[3] of which about 4 percent was spent on administrative costs in Australia compared with 12 to 15 percent in the US. Eighty percent of all hospital beds are publicly funded, but 50 percent of all specialists are based in private hospitals.[3] The government sets rates for all cognitive and procedural services reimbursed under Medicare. Physicians are not allowed to charge the difference between the Medicare rate and the physician's usual fee, but they can ask the patient to pay the entire bill, and the patient then applies for partial reimbursement from Medicare. The government prohibits the selling of so-called "gap" insurance, which would pay for differences between government-set fees and actual fees.

Submitted, revised, 1 April 1994.

From the Department of Family Practice, University of Michigan Medical Center, Ann Arbor. Address reprint requests to Thomas L. Schwenk, MD, Department of Family Practice, University of Michigan Medical Center, 1018 Fuller Street, Ann Arbor, MI 48109.

J Am Board Fam Pract: first published as 10.3122/jabfm.7.4.351 on 1 July 1994. Downloaded from http://www.jabfm.org/ on 9 October 2026 by guest. Protected by copyright.

Patients are encouraged by the government to pursue their usual care through the public system and to have physicians "bulk bill" Medicare (meaning accept direct reimbursement from Medicare at set rates). The government currently discourages private health insurance coverage by not providing tax deductibility or tax credits for policy premiums, although this issue is under intense discussion at present as a way of encouraging private care, which would decompress the overloaded public system. Stated government policy is that patients should not have out-of-pocket expenses for adequate public care. There was much public comment in the recent election campaign that federal government officials pursued their personal health care through the public system, but this care was likely not "usual" care and probably not available to most persons.

Medicare places great emphasis on the general practitioner for basic health care and health promotion. Subspecialists are not eligible for reimbursement by Medicare unless the patient is referred by a general practitioner.[2] Many patients see their general practitioner primarily to receive referrals, and the general practitioner otherwise provides only the most basic care. The majority of patients pursue basic, preventive, and catastrophic health care through the public system, including the services of the small number of consultants based at public hospitals. Approximately 40 percent of families purchase private health insurance to avoid increasingly long waits for elective subspecialty and surgical care (e.g., knee reconstruction), as well as more urgent procedures, such as coronary artery bypass and cholecystectomy; but this proportion is declining as a result of increasing premium costs (approximately Au$1500 per year for "top cover" [the most comprehensive coverage] for a family).[4] The government has made considerable efforts recently to shorten waiting lists, especially for elective surgical care in orthopedics and ophthalmology. The Australian public seems ambivalent about the public system, viewing it somewhat as a second-class system without choice of physician and with long waiting times for some types of care, yet moving away from private insurance due to increasing premium costs.

The net result of this system is that most Australians receive basic primary health care from their general practitioner, for which they pay nothing out of pocket, while often forgoing more elective surgical and subspecialty care. Although standard medical care outcomes and health statistics are quite favorable, probably as a result of the extensive system of publicly funded outreach services for pediatric, maternal, geriatric, and terminal care, many patients express frustration with the limits placed on them by the public system. They do enjoy, in contrast to the US situation, security from worry about the costs of catastrophic care, most of which is provided without charge in public hospitals where most medical training occurs. The cost of this publicly supported health care system is approximately 1 to 1.5 percent of gross income for all Australian workers.[3]

The major opposition party to the Labor party is the Liberal party, which is in fact the more conservative of the two parties, somewhat analogous to the US Republican party (I hope this comparison is not annoying for either party). In the recent federal election campaign, the Liberal party proposed premium rebates and tax credits for patients who had limited incomes to help purchase private health insurance, the elimination of bulk billing except for elderly patients and those of limited means, and the removal of the ban on gap insurance. In a close election, which many observers thought hinged on health care policies, these proposals were rejected.[1] Several proposals have reappeared since the election as a compromise strategy by the Labor party.

Role of the General Practitioner in the Australian Health Care System

General practice is more intrinsic to the overall structure of the health care system in Australia than in the US, but not necessarily more favorably viewed by the government and the public than are the family physicians in the US. Despite the structural requirement that specialists will be reimbursed by the government for their professional fees only if the patient has been referred to them by a general practitioner, general practice is often taken for granted by the system and generally demeaned by reimbursement policies. Primary health care seems to be viewed by the public and the government as if it were a public utility, ignored until it is unavailable or becomes too expensive. For example, because of strong incentives and encouragements that patients should not pay out of pocket for primary care unless they

J Am Board Fam Pract: first published as 10.3122/jabfm.7.4.351 on 1 July 1994. Downloaded from http://www.jabfm.org/ on 9 October 2026 by guest. Protected by copyright.

choose to do so, general practitioners participate at a high rate in bulk billing (approximately 65 percent of all services are bulk billed). General practitioners currently receive a reimbursement of about Au$18.50 for a routine office visit. The result of this level of reimbursement is that some general practitioners are essentially forced into a high-volume practice characterized by short office visits and the dispensing of a relatively large number of prescriptions per patient. The average rate of psychopharmacologic prescriptions per Australian patient is thought to be as much as two to three times the rate for US patients.

About 45 percent of all physicians are general practitioners. There is a marked maldistribution throughout the country, with actual surpluses in suburban areas (by official government estimate) and shortages in rural areas. The ratio of patients to general practitioner is 770:1 overall, ranging from 650:1 in urban and suburban areas to 1260:1 in rural areas.[5] By comparison, the overall ratio of patients to family practitioners in the US is 3750:1, with a range by state depending on the rural or urban nature of the state (e.g., 6560:1 for Massachusetts compared with 2250:1 in North Dakota).[6] Of interest is that the relation of these ratios is reversed in the US compared with Australia, with rural areas in the US having relatively greater numbers of family practitioners than urban areas, although there are still severe shortages in both areas compared with Australia.

The maldistribution of general practitioners in Australia is partly the result of a government policy of allowing the relatively free immigration of physicians from other countries, most of whom practice as general practitioners in suburban areas. Increasing restriction to such immigration is likely to occur in the near future. In addition, the total number of Australian physicians being trained is under study, with the possibility of a 10 percent decrease in medical school class size, a situation similar to recent discussions in Canada. The net result of this maldistribution is a major crisis in the delivery of rural health care, a particular problem in a country with such extraordinarily large rural areas. A measure of the size of the primary care access problem in rural areas is that the Royal Flying Doctor Service of Australia is thriving, with 13 bases and 40 aircraft supporting care to 140,000 patients per year, including 11,000 transports to hospitals.

The average gross income for general practitioners before taxes in 1989–90 was Au$139,000.[5] Practice costs are difficult to estimate but are probably lower than in the US and more similar to those in Canada, in the range of 40 to 50 percent of gross revenue, leaving a net income of about Au$70,000, compared with a mean net income for US family physicians of $108,000 in 1991.[6] Gross income for general practitioners increased 42 percent since 1984–5 compared with an increase in the Australian Consumer Price Index of 47.4 percent. By comparison, the average gross income of surgeons increased 61 percent to Au$230,000 and that of obstetrician-gynecologists increased 57 percent to Au$260,000.[5] General practitioners have fallen in relative income during the last few years, not only in relation to inflation but in relation to physicians of other specialties.

The average work week for general practitioners is 50 hours, and the average annual patient volume is 6,550,[7] figures that are not dissimilar to those for the US. Their scope of office practice is somewhat more limited than in the US because of the infrequent provision of office surgical procedures, an issue that is being actively addressed by professional organizations and training programs. The nature of hospital practice is similar to that in the US, with high involvement in rural areas and much less involvement in suburban and urban areas. Approximately 30 percent of general practitioners attended obstetric deliveries in 1988, with essentially all of these deliveries occurring in rural areas.[7] Patients make an average of almost five visits each year to general practitioners,[5] compared with an average of about three visits each year in most managed care settings in the US. There are suggestions that, because of poor Medicare bulk-bill reimbursement per unit of service, general practitioners encourage patients to make an excessive number of short, presumably unnecessary, visits.

Satisfaction surveys of patients regarding general practice services reveal complaints that seem similar in both frequency and type to those voiced by US patients. Of patients surveyed in 1992, 21.4 percent were dissatisfied with their ability to see a general practitioner at night or on the weekend, 20.2 percent with excessive waiting time in the office, 14.2 percent with getting a general practitioner to visit them at home, 12.9 percent with feeling rushed when having an office visit, and

J Am Board Fam Pract: first published as 10.3122/jabfm.7.4.351 on 1 July 1994. Downloaded from http://www.jabfm.org/ on 9 October 2026 by guest. Protected by copyright.

10.5 percent with feeling discouraged from asking questions of the general practitioner.[5]

Characteristics of the General Practice Educational System

Prospective physicians in Australia make the decision to study medicine at the end of high school, as is true for those in most fields of study and professions. A comprehensive examination and an evaluation of a student's high-school performance determine eligibility for various courses of university study, all of which are paid for by the Australian government and are essentially free to students. Statewide matching programs somewhat analogous to the US National Resident Matching Program determine the specific university and program of study for each high-school graduate. The course of study for medicine lasts 6 years, after which time a Bachelor of Medicine (MB) degree is awarded. The Doctor of Medicine (MD) degree is more analogous to a doctoral degree in a biomedical science and requires completion of a doctoral level graduate degree program involving considerable research training. The basic course of medical study for the MB degree emphasizes basic and clinical sciences without much opportunity for liberal arts education, leading to complaints that Australian physicians are too narrow in social outlook and education.

After completion of the Bachelor of Medicine degree, all students enter 3 years of hospital-based clinical training, following which a decision is made to pursue further specialty training, which can require an additional 5 to 8 years. A physician can practice as a nonvocationally registered general practitioner following the 3 years of basic clinical training. An increasing number of graduates choosing general practice as a career, however, pursue an additional 3 years of outpatient training in the Family Medicine Programme.

The Family Medicine Programme was established with government support in 1973 by the Royal Australian College of General Practitioners (RACGP) as an ambulatory-based training program using credentialed private practices as training sites. Despite RACGP involvement, there has been a lack of acceptance of the program and appreciation of its value by many general practitioners. Vocational registration, equivalent to board certification in the US, has been linked to Family Medicine Programme training only since 1989. The RACGP joined forces with Medicare to strengthen the Family Medicine Programme system by increasing reimbursement to vocationally registered general practitioners, as well as limiting future eligibility for registration to those having formal vocational training. General practitioners are frequently not supportive of postgraduate training and registration, because of concerns about the relevance of the training, its length, and the government's involvement.[5] Of approximately 22,000 general practitioners in Australia, about 6,000 are vocationally registered or eligible to do so.[7] Despite Family Medicine Programme training and vocational registration, the specialty is viewed by patients, specialists, and even some general practitioners as being less rigorous and quality controlled than traditional medical and surgical specialties.

Compared with academic family practice programs in the US, there is a relative lack of support for, and productivity in, general practice research,[8] leading to low esteem in the eyes of the traditional academic medical establishment. This lack of support exists in a milieu of minimal government and foundation support for biomedical research in general compared with the US, so academic general practice receives a small slice of an already small financial "pie." Recent proposals have been made by the government to establish funding mechanisms for community-based general practice research based in community networks of practicing physicians,[5,7,9] with a coordinating, albeit ill-defined, role to be played by university departments of general practice. Practice-based research already exists through a sentinel practice network called ASPREN (Australian Sentinel Practice Research Network), which is similar to networks in the US, such as the Ambulatory Sentinel Practice Network (ASPN) and the Michigan Research Network (MIRNET).

There is a notable lack of enthusiasm by the RACGP for developing and sanctioning specialty areas of emphasis in general practice, such as geriatrics or sports medicine. General practitioners with sports medicine interest and experience chose to establish a separate college, the Australian College of Sports Physicians (ACSP), as a vehicle to develop the training, recognition, and certification of primary care sports medicine

J Am Board Fam Pract: first published as 10.3122/jabfm.7.4.351 on 1 July 1994. Downloaded from http://www.jabfm.org/ on 9 October 2026 by guest. Protected by copyright.

physicians. The ACSP is not recognized by the government as an official college for purposes of increased reimbursement, although there is progress in that direction. The relationship between the RACGP and ACSP is lukewarm at best.

Recent Proposals to Strengthen the Role of General Practice

A 1991 strategic planning project conducted jointly by the Australian Medical Association (AMA), the RACGP, and the Commonwealth government to address ways to enhance general practice made recommendations in five areas[5]: (1) workforce planning to address issues of oversupply and maldistribution of general practitioners; (2) support for appropriate postgraduate training, including faculty development for trainers and increased numbers of training practices; (3) the establishment of local divisions of general practice with increased collaboration, integration, and communication as a way of increasing professional and political influence; (4) accreditation of practices for purposes of quality assurance and professional recognition; and (5) increased remuneration for general practitioners. The implementation of these recommendations has just begun, so results of this project are unclear, but the mere fact of their existence and the attention paid to general practitioners by the government have raised morale among general practice academic and professional leaders.

Implications for Family Practice in the United States

The net result of the Australian government policies, medical education traditions, and social forces described above is that Australian general practitioners experience lesser levels of political and organizational strength than do US family physicians. Individual general practitioners do not appear to benefit professionally or economically from the fact that general practice is intrinsic to the Australian health care system. The income, standard of living, and professional respect of US family physicians are superior in general to that of Australian general practitioners. The strong collaboration between the various professional family practice organizations in the US, both academic and practicing, appears to be far more effective in representing the professional, educational, and economic interests of US family physicians than is true for the corresponding Australian organizations.

The development of an academic infrastructure in general practice appears to be rudimentary at best, with small university faculties concentrating almost solely on medical student teaching. A recent study found only 20 academic general practitioners at the rank of lecturer (roughly equivalent to an assistant professor) or higher in the entire country.[8] There is considerable discontinuity of education for general practitioners, especially because the postgraduate training provided by the Family Medicine Programme is sponsored by the government and implemented in private practices that are physically and administratively removed from university departments. These departments concentrate primarily on limited medical student teaching opportunities.

Family practice in the US has benefited tremendously from the strong collaborations among all family practice organizations, particularly among the American Academy of Family Physicians (AAFP), the American Board of Family Practice (ABFP), and the Society of Teachers of Family Medicine (STFM). These close working relations, now including the Association of Departments of Family Medicine (ADFM) and the Association of Family Practice Residency Directors (AFPRD), must be preserved and strengthened. The political influence of the AAFP and STFM, in particular, on government and payer policies is of inestimable value to individual family physicians and should be appreciated and nurtured, especially in the coming era of health care reform. The cooperative efforts of all family practice organizations to enhance the discipline, irrespective of individual organizational interests, are impressive compared with the situation in Australia, where professional and academic organizations show less agreement regarding the relative legitimacy of each constituency.

The relatively high level of integration of family practice education at all levels (medical student, resident, and practicing physician) is a major strength of the US system and should be further enhanced, particularly by working for favorable changes in the funding of graduate medical education. The collective efforts of STFM, AFPRD, and ADFM to increase the strength and stability of the academic and educational bases of family practice are critical to the future success of

J Am Board Fam Pract: first published as 10.3122/jabfm.7.4.351 on 1 July 1994. Downloaded from http://www.jabfm.org/ on 9 October 2026 by guest. Protected by copyright.

our discipline, particularly in times of increasing medical student interest, the proposed need for specialist retraining, and the need to expand opportunities for high-quality graduate training and postgraduate education.

Family practice draws considerable political strength from its relative scarcity and from the tendency for family physicians to provide care for underserved rural and urban populations. This source of strength is particularly important in the face of difficulty in defining to the satisfaction of academic medical centers the unique and critical responsibilities of family physicians. The social commitment of the discipline is an important component of its overall success, not only for moral and professional reasons, but because of the resultant social and governmental support it generates. The current supply and distribution characteristics of family practice are a source of considerable support in all proposals to enhance the specialty. The political value of meeting the country's primary care needs cannot be overestimated as we work to establish the intrinsic importance of family physicians to the entire system. We should take full advantage of the current attitude of many government, managed care, and academic constituencies, which might best be summarized as "We aren't quite sure what family physicians do, but we need a lot more of it."

Family physicians around the world seem to undervalue their services, with Australian general practitioners being willing to accept an absurdly low rate of reimbursement from the government. I met a private solo general practitioner who has refused from the beginning of her practice to bulk bill, has always charged the patient her full fee, and has therefore been able financially to see a smaller volume of patients than usual and spend more time with them. She has an extremely loyal group of patients and a thriving practice. This model offers lessons to US family practitioners as we begin to negotiate with managed care organizations regarding the value of our services.

A system of basic primary care services funded on a nationalized basis, as a sort of safety net for all citizens, is a highly desirable goal. On the other hand, a system that is so completely nationalized that patients have no ability to pay for or be insured privately for care as they choose to receive it, as is true to a considerable extent in Australia, appears much less desirable. Such nationalized care would likely result in primary care services being relatively demeaned. US family physicians need to be careful to differentiate those services they provide that are "basic" from those that represent higher levels of preventive, case management, psychosocial, or acute care. They also need to charge for those services appropriately, either directly or through negotiations regarding the time necessary to provide such services on a salaried basis in managed care settings.

As is frequently true for cross-cultural professional studies, such as that reported here, some of the grass on the other side of the fence appears much greener than that on our side, some barely greener, and some quite yellowed and dry. While the Australian general practitioner has certain attributes of which we can be envious, such as the opportunity to provide basic primary care services to essentially all Australians, I left the land down under with a greater appreciation for the many impressive, and often unappreciated, political and social strengths of family practice in the US. These strengths have resulted from the cumulative effect of the work of many dedicated persons during the past 25 years, and their presence bodes well for the future of family practice in the coming era of health care reform.

References

1. Gittins R. Coalition's bedside manner fails to reassure the patient. The Age 1993, March 20.
2. Grumbach K, Fry J. Managing primary care in the United States and in the United Kingdom. N Engl J Med 1993; 328:940-5.
3. Lawson JS. Lessons from the Australian system. Physician Executive 1993; 19(6):17-20.
4. Health insurance. The Age 1993, April 19.
5. The future of general practice, Melbourne, Victoria: National Health Strategy Issues Paper No. 3, National Health Strategy, 1992.
6. Facts about family practice, Kansas City, MO: American Academy of Family Physicians, 1993.
7. Doessel DP, editor. Towards evaluation in general practice: a workshop on vocational registration, Canberra: Department of Community Services and Health, 1990.
8. Kamien M. Academic general practice in Australian medical schools. Sydney, Australia: Australian Association for Academic General Practice, 1990.
9. Medicare: so much stronger now, 1992-93 Budget Related Paper No. 8: Health Care for All Australians: 1992-93 Reforms, Minister for Health, Housing and Community Services, Commonwealth of Australia, 1992.

J Am Board Fam Pract: first published as 10.3122/jabfm.7.4.351 on 1 July 1994. Downloaded from http://www.jabfm.org/ on 9 October 2026 by guest. Protected by copyright.