Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Comparing Australian and US Health Care Systems

To the Editor: Comparisons between health systems, particularly those of the Western world, which have a similar cultural heritage, can reveal important lessons for the analysts and those analyzed. Dr. Schwenk's[1] critique of the Australian system pointed out many of its weaknesses and strengths.

The Australian system is underpinned by a taxation-based universal insurance system that has a longer history of providing publicly funded hospital and specialist care than of general practitioner or private subspecialty care. The philosophy of health care as a "right" underlies the public provision of health services; however, many recent medical and governmental political figures state that the apparent failure of the public hospital system to meet public demand has been caused by the failure of the financially well-off citizens to carry private insurance and thus afford private hospital care.

The balance of the work force between general practice and the subspecialties reflects a system that restricts training positions for subspecialties — medical graduates' career choices appear to reflect the opportunities available — but whether the balance would be maintained with unrestricted subspeciality training is open to question. By a combination of design and accident, general practitioners have been excluded from hospital and procedural medicine. This exclusion is combined with a "shortage" of some procedural specialists and with private and taxation-based insurance poorly rewarding nonprocedural care. As a result, general practice incomes are substantially lower than in other branches of medicine. This income differential between procedural and nonprocedural specialties is also true of the US health care system.

The healthy state of family practice as an academic discipline in the US might reflect two major differences from the Australian environment: first, the high relative cost of medical care in the US, particularly in the procedural areas — a cost that forces insurers to consider mechanisms to reduce unnecessary procedural medicine; and second, the low proportion of US physicians in family practice or other primary care specialties. The latter factor provides an enhanced dollar value to the services that are provided by the generalists. It might well be possible that if the proportion of generalists in the US increased to Australian levels, US health insurers might deem it unnecessary to reward generalists as highly as they do currently.

For Australian academic general practitioners, the failure to develop an educational system that allows a continuum of delivery from predoctoral, through residency, and into continuing professional education is a major concern. Predoctoral education can be seen as fitting a new graduate to function as a hospital intern. General practice can thus be viewed as of little relevance predoctorally. We hope this will eventually change.

Nevertheless, the Australian system has its positive side. Inequity in service provision is less than in the US; with the high level of publicly insured primary care, most persons are in the same health care plan. Patients choose their practitioner; no HMO or employer can determine the care provider. Services required for psychiatric conditions are not restricted. Malpractice claims are rare; thus medicine embraces humanism more and values less the technological disease-based focus at the heart of much US angst. Finally, primary care services are provided almost entirely by general practitioners, which promotes comprehensive family care rather than the more fragmented approach seen when multiple primary care providers with different orientations co-exist and compete.

Comparisons between health care systems are valuable, as all systems have some features worthy of adoption. As Dr. Schwenk noted, such comparisons allow one to view the strengths and weaknesses of one's own environment and to see new challenges. Both health systems benefit from programs of faculty and predoctoral student exchange.

Alex N. Thomson, MD
Department of Primary Health Care,
Rural Health, and General Practice
University of Tasmania

References

1. Schwenk TL. The role of the general practitioner in the Australian health care system: lessons for US family physicians. J Am Board Fam Pract 1994; 7:351-6.

Health Care Reform

To the Editor: These are tough words for tough times. I regret that I must write them, but as do many persons, I believe strongly that the Clinton agenda to nationalize health care is profoundly immoral and poses a serious threat to the integrity of the United States of America. The threat is such that words of propaganda and support for that agenda cannot be allowed to stand unchallenged in a publication representing an organization to which I belong. I therefore must strongly criticize the views expressed by Dr. Howard Brody[1] in the special communication that you recently published.

J Am Board Fam Pract: first published as 10.3122/jabfm.7.5.456 on 1 September 1994. Downloaded from http://www.jabfm.org/ on 18 November 2026 by guest. Protected by copyright.