Out of Hours

International primary care snapshots:

Australia and Brazil

CHANGES TO GENERAL PRACTICE AND PRIMARY CARE IN AUSTRALIA 2014

Australia has enjoyed a universal health insurance scheme, Medicare, for 40 years. Introduced by a Labor government in 1974, no successive Labor or Conservative (Liberal) government has been brave enough to tamper with this scheme fearing electoral backlash. This is no longer the case. The newly-elected Conservative government proposes to change all this, provided its bills pass the Senate or Upper House. Faced with concerns about a budget deficit and fears that an ageing population with increased incidence of chronic and complex disease will make Medicare unaffordable, they have introduced a mandatory A\$7.00 patient co-payment for GP consultations and out-of-hospital pathology and radiology, concurrently reducing the Medicare contribution by A\$5.00. Specialists are unaffected. The government proposes that the A\$5.00 saving will go into a A\$20 billion medical research 'future fund' designed to support research to find cures for chronic disease, with dementia being singled out. These changes are supposed to come into effect in July 2015 and will be accompanied by an extra A\$5.00 payment for pharmaceuticals. These changes have been universally opposed by the Royal Australian College of General Practitioners (RACGP), Australian College of Rural and Remote Medicine, the Australian Medical Association, Doctors Reform Society, senior medical academics, the majority of public opinion, and, of course, the opposition parties. The changes are seen to discriminate against the most vulnerable in the community, namely the poor and low-income earners who may think twice about going to the doctor. The link between the A\$5.00 saving and a medical research fund has been considered spurious.

Australia's population of 23 million is ageing. Between 1973 and 2013 the number of people aged >65 years has tripled from 1.1 million to 3.3 million, comprising 14% of the population (tipped to rise to 22% by 2035), and there has been a sixfold increase in those aged >85 years from 73 100 to 439 600 [Australian Institute of Health and Welfare, 2014]. It is also true that our health expenditure has risen over the past decade. In 2011–2012, Australia spent around A\$140 billion on health, 1.7 times more in real terms compared with 2001–

Lucky country? Sydney is the state capital of New South Wales and the most populous city in Australia and Oceania.

2002. Health expenditure is now 9.5% of GDP compared with 6.8% two decades ago. However, the cost of GP-related services in 2011–2012 was only A\$9.7 billion. The reason for targeting GPs in budget cuts is that they are the gatekeepers to the system and are hence considered to influence downstream expenditure.

The proposed changes to Medicare are opposed by a hostile Senate with the government furiously coming up with unacceptable compromises to effect change by July 2015.

Other changes introduced in the 2014 May budget included a dismantling of so-called Medicare Locals and their replacement with a lesser number of 'Primary Care Networks'. The Networks have similarities to the former UK 'Primary Care Trusts' and will encompass GPs and other allied health professionals working in alignment with State Health Authorities to enhance quality of primary care and public health in local regions.

In 2000, following a review of the RACGP Family Medicine Training programme, the then conservative government removed the training responsibilities from the RACGP and established General Practice Education and Training Inc. (GPET) with training delivered through 17 regional training providers. The 3-year training programme now takes in 1500 registrars a year. The new conservative government has decided to dismantle GPET and bring training into the Federal Health Department with

a significant reduction in the number of providers, possibly six to seven, perhaps one in each State or Territory.

The new government has also introduced changes to the Higher Education System, which may have indirect and unforeseen consequences on general practice. From 2016, universities will be able to set their own fees and government will reduce fee subsidisation by 20%. This means that a medical degree, which currently costs an Australian student in the vicinity of A\$45 000–A\$50 000 with government subsidy, may cost A\$120 000. This will make it harder for students from lower socioeconomic backgrounds to study medicine and potentially change the demographic composition of the medical workforce. In a diverse, multicultural society such as Australia this may have undesirable consequences for the medical profession in general and general practice in particular. Like the Medicare legislation, this legislation has reached an impasse in the Senate.

By international standards Australia is a wealthy country. Many see these budget-driven changes to be draconian, shortsighted, and not designed to create a thinking, innovative economy with a fair and equitable health system. Time will tell.

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REGULATING FOREIGN RECRUITS INTO PRIMARY CARE IN BRAZIL

Brazil's National Health System (Sistema Unico de Saude — SUS) is enshrined in the 1988 Constitution as a legal obligation for the state to provide to all its citizens. With an integrated public health and primary care programme at its core, the Family Health Strategy (Estrategia Saude da Familia) has provided comprehensive primary care services to well over 100 million people through 35 000 family health teams and 250 000 community health workers in a little over two decades.¹ Its impact on equity and key population health outcomes is impressive.^{2,3} Successive governments have worked hard to encourage the expansion of primary care training and education in universities and medical schools. However, recently the expansion has plateaued and residency programmes in family medicine, established to fuel the expansion, struggle to fill their places.

On 22 October 2014, it was 1 year since President Dilma Rousseff signed Law No. 12 871, enabling Brazilians qualified abroad and foreign medical doctors to work in Brazil's national health system.⁴ The purpose was to decrease the shortage of medical doctors in priority regions and to strengthen the provision of primary care. So far, it seems to have been successful. As of 18 February 2015, 14 462 doctors have been recruited through the More Doctors programme in 3700 municipalities (34 of which are in indigenous populations).⁵ Priority was given to returning Brazilians who graduated overseas, and retirees, but subsequent phases were expanded to include applications from foreign graduates.

Currently, almost 80% of the More Doctors recruits are from Cuba.⁵ Recruits are only allowed to work in primary care and under the supervision of local Higher Education Institutions and Medical Schools.

At first sight, this would not be particularly controversial. In the UK, for example, nearly 20% of all doctors have trained abroad. However, the More Doctors programme in Brazil has raised serious concerns. The professional medical associations have fought it, protested against it, and even sued the government in the Supreme Court. Their concern is that the More Doctors recruits do not need to revalidate their medical diploma through the usual channels, and argue that it is unethical to permit a doctor to practise medicine without having first established whether he/she is competent to do so. In addition, the Cuban doctors' salaries are paid first to their government: they receive only a proportion of this payment, leading some to

describe their recruitment as 'slave labour'.⁶ Others have noted that the More Doctors programme is a covert attempt to secure Brazil's economic interests in Cuba. The doctors' salaries provide over US\$250 million per annum in hard currency to Cuba, easing inflation, while Brazil positions itself as a preferred partner for major economic redevelopment programmes.⁷ If true, then this is a particularly good example of health diplomacy.

A policy of this size and scope will always court controversy; however, the issue is that the training and regulation of medical doctors in Brazil has not kept pace with the rapid expansion of the national health system. The medical associations are right to protect the public from quacks and to question the comparability of medical education in other countries. However, they have done little to regulate doctor absenteeism and multiple job-holding, which has in part led to the need for the More Doctors programme.

Furthermore, their attempts to standardise the revalidation process resulted in controversy when only 13% of candidates passed the exams,⁸ far lower than that achieved in the UK PLAB exam for foreign doctors.⁹ The Brazilian Family Health Strategy was modelled to a large degree on the Cuban system of primary care. Early assessments show that patients are very supportive of the Cuban doctors, preferring their style of practice, finding them to be more holistic and responsive than their Brazilian counterparts.

Although it was a closely-fought election, on 22 October 2014 President Dilma Rousseff won her second term. It is encouraging that the latest recruitment round of the More Doctors programme in January 2015 saw 95% of the vacancies filled by Brazilian doctors,⁵ however, the medical associations still need to get behind it, starting with promoting primary care as a decent choice for Brazilian medical graduates.

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