Tim Senior

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Crossing the borders

It's only when you come up against a border that you know it exists. Being in Australia made me more English than I ever was in England, and this is because of bumping across the border between English and Australian cultures. Similarly, it was possible for me to go through training in the NHS and believe that this was just the way health systems had to work. Learning another health system brought me up against another border, showing an alternative to the NHS.

Like all health systems, the Australian one is complex. It is based on Fee-For-Service — patients pay a fee for a particular service from a GP. Patients are then able to get a rebate from the Federal Government Medicare insurance system. These rebates, you won't be surprised to learn, don't keep pace with the actual cost of providing care, so many patients pay a gap fee to their doctor. However, the doctor can accept that rebate as the full payment for their service, and in this case the GP is free at the point of care, especially important in areas where patients can't afford a co-payment.

These fees for service are generated by the doctor (there are a few exceptions where nurses can generate billings) but these are the main income for the entire practice, so is necessary to pay staff, rent, electricity, and consumables. GPs generally are paid a percentage of their billings, with the rest funding the practice.

Why mention all this? Because the difference between a Fee-For-Service system and a system based on capitation and the Quality and Outcomes Framework produce very different ways of working. In Australia the incentive is to see lots of patients in short consultations. This means GPs doing more complex work — multiple chronic diseases, complex mental health, preventive work — are paid less than those doing acute general practice. There's almost nothing for anything that doesn't involve patient contact. Some practices can get payments for something that is called quality improvement, but is really just for reporting limited amounts of data to government agencies.

It's not hard to see how a system based on Fee-For-Service would be stretched to breaking point with an ageing population, and also in areas of poverty, where there are more complex chronic diseases, with a complex mix of mental health and social problems. This system also results in a gender pay gap of an average of 11 AUD per hour,[1] because of the different sorts of problems managed by male and female GPs.

There's a general acceptance that Fee-For-Service was designed for a system of mainly acute general practice, and that it doesn't work for the needs of a modern population. However, try to change the system to anything else, and there is an outcry. Capitation? Just a system for limiting funding for medical services. To a government, though, all systems are there to have funding limited! Again, we bump up against the boundary of our own system, and our imagination of something different.

I don't know what a perfect system would look like. I'd like to think it would support quality improvement and coordination of care in a complex system, as well as management of complex multimorbidity and prevention. That sort of care looks expensive and is invisible to policy makers without expertise in health care, and who are, usually, by definition, younger and employed.

Funding general practice may well look expensive, but it's certainly not as expensive as not funding us. While a perfect system would be nice, just crossing the borders to imagine an alternative to what we have may be our most important step.

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