

Out of Hours

Grass is greener?

General practice in England and Australia

BACKGROUND

General practice in England is experiencing unprecedented levels of demand¹ and GPs and their practice teams are struggling to cope.² Days are long but time with each individual patient is short. Getting on a plane to a place where the working conditions appear to be more tolerable, and the weather is better, may seem an attractive option for some, although only a small proportion of the overall workforce actually do.³ Australia is a country in need of GPs, particularly in rural areas, and is a popular destination for doctors leaving the NHS to work abroad.⁴

It would be difficult to determine objectively which country is the better place to practise as a GP, but it is worth exploring the key similarities and differences from a health services viewpoint. By looking across continents, we can consider alternative ways of working and observe the consequences of any significant change in the way general practice is delivered.

THE POPULATION AND GENERAL PRACTICE

Australia has a population of nearly 24 million; well under half that of England but in an area 50 times the size.⁵ Eighty per cent of Australians live within an hour of the ocean, and most live in cities, although a significant number, including indigenous communities, inhabit rural and remote areas. Australia is facing demographic change with an ageing population and increasing burden of chronic disease and multimorbidity. And, as in the NHS, general practice is the gatekeeper of the Australian health system.

In 2015, around 85% of the population consulted their GP, at an average rate of 5.6 visits per person, increasing from 4.3 visits per year a decade before.^{6,7} GP numbers have increased to meet this growing demand, although most growth has been in urban areas, with rural areas struggling to recruit, worsening disparities in healthcare provision.

In England, the average consultation rate in general practice was 8.3 per patient per year but this included contact with other professionals including general practice nurses. Overall, Australia has a greater number of GPs per head of population compared with England. In 2013–2014, there were 87.8 full-time equivalent GPs per 100 000 in Australia compared with 59.6 GPs per 100 000 in England.^{1,8}

HOW IS GENERAL PRACTICE FUNDED?

General practice in England is allocated a part of the overall NHS budget generated from tax revenue collected by the UK government. Practices receive annual capitation payments depending on the demographic characteristics of the population they serve. The Australian Federal Government funds general practice through payments to health professionals via the Medicare Benefits Schedule (MBS). Medicare has been Australia's national public insurer for over 30 years, and the MBS determines fees payable to doctors for particular services such as consultations or procedures.

GPs in Australia are paid under a fee for service (FFS) model, and can either accept the MBS payment as full compensation, or can charge an out-of-pocket fee. The FFS model creates a financial incentive for doctors to increase their activity in order to generate more income. Although more health care may be desired, this may lead to oversupply of services, making health spending, and therefore budgeting, more difficult to predict. The Australian government is currently undertaking a review of this funding model.⁹ Capitation alone, like FFS alone, does not reward quality of care and, in its simplest form, can act as a disincentive to productivity as payment is received regardless of the amount of care offered to patients. In both countries, performance incentives have been introduced to encourage better quality of care and to decrease the undesired effects of capitation and FFS. In Australia, the Practice Incentives Program provides capacity payments to practices, in addition to some provider incentives for achievement of chronic disease targets.

These payments represent a small percentage of a doctor's income, and have been seen to be less influential on general practice activity than larger-scale schemes, such as the QOF in England. The different payment mechanisms, and the range of income dependent on responsibilities (for example, partner versus salaried), and activity within each country, make it difficult to compare the average pay of GPs in England and Australia. A further key difference between England and Australia is the overall funding responsibility. The single-funder nature of the NHS allows for some efficiencies and permits large-scale transformational change. In Australia, there are separate funding streams for general

practice and residential care (managed by the Federal Government) and hospital and other community health services (administered by the eight States and Territory Governments). Agreement between all these jurisdictions is difficult to achieve, duplication of services is a common problem, and health system reforms move slowly as a result.

THE NATURE OF GP WORK

A typical working day for a GP in England includes a combination of face-to-face consultations, telephone calls, signing repeat prescriptions, following up results, corresponding with secondary care, and other administrative duties. Work the GP does outside the consultation can decrease the need for patients to physically attend, and this is remunerated within capitation payments. The length of a consultation is usually 10 minutes and, although longer appointments could be made available, demand is often too high to make this possible. Conversely, in Australia, an average consultation lasts 15 minutes. Only face-to-face care is billable through Medicare (with a few exceptions) creating a disincentive for completing administrative tasks outside of appointments, and patients may need to make appointments for care that could potentially be dealt with remotely.

In England, members of the general practice team, such as practice nurses or pharmacists, provide many aspects of ongoing care and can in some circumstances remove the need to see a GP altogether. Delegation of tasks varies between Australian practices, again as a result of the funding structure, which encourages face-to-face GP care. Electronic health records are used in practices in England and Australia to ensure systematic recording of medical information. Formal record sharing does not exist between practices in Australia, despite attempts to overcome this through the development of a national Patient Controlled Electronic Health Record. In both countries, there has been a decrease in the proportion of solo practitioners, and a trend towards practices becoming larger. This has led to the development of meso-level organisations tasked with understanding local needs and commissioning services for a defined population, with performance management of both providers and practices. England's CCGs are more advanced in this process than the Australian Primary Health Networks

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(PHNs), which have been established for less than a year, and whose capacity to influence provider and health system performance remains to be seen.

PATIENT EXPERIENCE — CHOICE AND CONTINUITY

Patients in England register with a practice near their home, whereas Australian patients do not formally register with a GP or practice. Patients may attend multiple general practices in different locations and see several GPs. Although this can cause fragmentation of care, it does improve access to services and increases competition between practices, particularly in urban areas. Despite the current freeze in the MBS rebate, over 80% of general practice consultations are delivered without a cost to the patient. However, when an out-of-pocket fee is charged, it averages around 32 Australian dollars.¹⁰

In the UK, the founding principle of the NHS is the provision of free universal health cover, and there is pride in a service that is utilised by everyone, regardless of their means. In Australia, there is a well-developed private hospital sector, and even in primary care there is a sense politically that those who can afford to contribute to their health costs should do so. The goal appears to be more about universal access to care rather than universal free care. Fragmented care is a potential problem in both settings. Without patient registration, Australian practices are less able to define their population, potentially decreasing the affiliation between practices and patients, and reducing continuity of care. In England, a patient may see multiple GPs within the same practice (one doctor may order a test, a second review the result, and a third see the patient in a follow-up appointment). So although the patient may have an allocated practice, or even a nominated GP, there is still the potential for decreased continuity of care even with only one provider.

CONCLUSION

General practice has a fundamental place in both English and Australian health care but the systems differ in their capacity, funding, and logistics. In Australia, patients have more

choice of provider and GPs have greater control of their workload, and radiology and pathology assessment, whereas the funding model in the NHS provides continuity and universal free access to services for patients, but limits the ability of GPs to manage demand. Neither system has the advantage. English general practice offers the health system benefits of a registered population and incentives to organise team-based care, whereas Australia offers choice and the possibility of continuity, at least if patients enjoy a positive practitioner relationship. However, there is greater potential for duplication of effort and disincentives to organise care outside of the consultation.

What is clear, however, is that policymakers in both countries need to ensure healthcare provision can meet the needs of their ageing populations. The only way to do this is by putting general practice truly at the centre of both healthcare systems. Funding ratios should shift from hospitals into the community, roles within the general practice team, particularly nursing, should be strengthened, and general practice quality increased through recruitment of more GPs and retention of the existing workforce. Only by taking action now will holistic, patient-centred health care remain available to all in England and Australia.

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Competing interests

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