The Inside Scoop Part 2: A comparison of the US and Australian Healthcare Systems

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While the structure and the cost of the US Health system varies significantly to what we have in Australia, the most fascinating aspects extend beyond the surface. As a patient in the US health system I have personally experienced the variations in clinical patient management.

The first thing to note is that the General Practitioner, as we know it, just does not exist in America

The Australian GP remains the first port of call for all ages and all medical conditions. They play a crucial role in continuity of patient care, patient advocacy and are the gatekeeper providing access to a specialist in another field. In the USA, instead of one practitioner managing a person’s overall health, Paediatricians, Obstetricians, Family medicine practitioners and Internal medicine physicians all fall under the umbrella term of a “primary care provider” [1]. In addition, most insurance plans allow patients to self refer to any physician [1]. This means that even though you can book in to see a Family Medicine doctor, to manage your various complaints, they seem to be a less popular choice in the community for the simple reason that you can see physician specialising in the field of your problem directly for about the same cost and wait time as a generalist.

When I first arrived in the US, I booked into see a Family Physician for an asthma review and prescriptions and I was repeatedly questioned by others as to why I didn’t just see a respiratory specialist. It seems that if you have a rash, you call a dermatologist. If you have reflux, you book in to see a gastroenterologist. Paediatricians are a one-stop shop for all child health concerns, from “well checks” which includes vaccinations, to general coughs and colds and more complex conditions. Gynaecologists will perform your annual women’s health check.
With this structure in place, it's easy to see how preventative healthcare fails in the US, especially for adults. The combination of cost, polarised speciality care for individual problems and the lack of the central role of a primary health care manager, such as a GP, can lead to gaping holes in a patient’s overall health care. For example, who takes on the role of managing and monitoring your blood pressure, weight, cholesterol, and cancer screening if you don’t have a GP? Is it safe, efficient, or appropriate to let a patient book in to see a respiratory consultant for shortness of breath when in fact a simple history suggests a cardiac origin? Who acts as a patients advocate? The cohesiveness of comprehensive health care is lost.

The exception to this structure of care is in some large healthcare systems such as the military facilities, where primary care physicians play a role similar to the Australian GP [1]. Patients are allocated an on base “Primary Care Manager” (PCM) who manages all their acute and chronic health conditions. Similar to in Australia, they are the gatekeepers to providing access to a specialist physician. While this arrangement enables continuity of care, you often do not get a choice of provider, and due to the demand, there are difficulties in accessing services. Obtaining off base referrals can also be difficult if you don’t meet the insurance policies strict criteria for referral and it must be deemed appropriate by your PCM. To enable more choice and flexibility many military members, myself included, hence choose to change their insurance policy from a completely free service, to one that has co-payments and allow easy self referral to an off base provider.

**So what about if you are acutely unwell?**

You have three options: Attempt to see your primary care provider if you have one (e.g. Paediatrician for children, Internal physician or Family medicine practitioner for adults), present to an Urgent Care Centre or present to a Hospital Emergency Department. From my experience, accessing your ‘usual’ doctor when sick is challenging. The clinic hours are often restricted to Monday-Friday 8am-5pm and obtaining an appointment involves discussing your presenting complaint with the reception staff or triage nurse at length to plead your case. Many times, you are still referred to your local urgent care centre instead as they are unable to accommodate you. Urgent Care Centres are set up as a stand alone ‘walk in’ emergency clinic that are open after hours and have onsite pathology and radiology services. They are everywhere. For many Americans, their experience of seeing a doctor growing up was purely confined to these ‘as needed’ urgent consultations.

While the presence of these clinics obviously plays an important and valuable role in freeing up emergency departments for actual emergencies, one concern I have is that it once again relies on the patient making a decision about their care that they may not be sufficiently knowledgeable to make. For example, if you are suffering from symptoms of a stroke or you have acute chest pain, Urgent Care Centres are not well equipped to deal with such cases. It is also well known that the cost of being seen in an ED is much higher than being seen in an urgent care facility, which again may lead to inappropriate presentations to these centres for time critical emergencies and a resulting compromise to patient clinical outcomes.

**So you have an appointment to be seen – what can you expect?**
A visit to a doctor's office is also vastly different. While in Australia, the health system primarily consists of a team of nurses, doctors and allied health professionals, in the United States there are multiple tiers of healthcare workers. Either a medical technician or nurse sees you first, to take your vitals and to clarify the reason for your presentation. Then, either a Physician Assistant (PA), Nurse Practitioner (NP) or Physician (either a Medical Doctor or Doctor of Osteopathic Medicine) enters the room to see you for a focused consultation that is in essence more streamlined, fast and directed, based on the information provided.

While this set up allows the physician to see more patients, in my opinion it also may leave less room for the development of rapport and hidden agendas are less likely to be disclosed. I have experienced a few rather impersonal rushed consultations over the past year, where the doctor’s agenda seems to be more important than finding out the patient’s concerns. It leads to the feeling that the practice of medicine is a little more paternalistic in the USA compared to Australia where there is a focus on actively encouraging patients to be involved in the decision making process.

While Australia certainly has a doctor shortage, the physician: patient ratio in the USA is still lower than that in Australia [2]. The physicians here are feeling overworked and stretched, and are relying on mid-level health care workers to work as part of their team and take on some of the patient load. While, most of the time, this still requires a level of supervision by a medical doctor, the laws around this are changing. One current debate centres around the increasing number of NPs, who in some states have the right to independent practice despite significantly lower levels of clinical experience and training than MDs. More and more mid-level health care workers are therefore being employed in preference to medical doctors as they are “cheaper” and can essentially function in the same way. In terms of quality patient care, there are rising concerns amongst physicians about the future. Australia is only just beginning to expand and train NPs, and PAs so this will soon also need to be addressed in our country.

The USA is certainly far more advanced in utilising electronic health records. Appointments, previous consultation notes and an internal messaging and payment system are readily accessible through a patient’s health portal at the local doctors office. Pharmacy prescriptions are mostly electronic and directly sent to your pharmacy of choice. America also has drive through pharmacies where you can pre-order over the phone and pick up your prescription. Australia could certainly benefit from such a system to increase efficiency, communication between providers and convenience for patients.

Now let’s have a quick look at the medical education systems – are they similar?

In terms of medical education, both countries require a similar amount of university training. In the USA medical degrees take 4 years to complete with a prior undergraduate degree as a pre-requisite, similar to many Australian graduate entry medical schools. Where it differs, is in postgraduate training. In third year of medical school, students in the USA start to focus on their area of interest and complete electives. They then sit national board exams (USMLE) and apply directly to speciality residency programs from medical school, most of which are 3 to 4 years duration and many also include an intern year [1]. Some surgical residencies do take longer – about 5 to 7 years to complete. The residency programs are very competitive with a large
number of unmatched students per year. To maximise your chances of getting a ‘match’ many graduates apply to programs all across America and are forced to relocate away from their support networks.

This is vastly different to Australia where all domestic graduates are guaranteed an intern position in a public hospital in their state of graduation. Furthermore, there is less pressure to decide on your future speciality at graduation. Most decisions about your speciality path are made at the PGY2 or PGY3 stage after completing 2 to 3 years of core hospital rotations through all disciplines. On average, most doctors take 8 to 10 years after medical school to obtain specialist qualifications and practice independently in Australia. There are clear advantages and disadvantages to both systems – the USA system is more streamlined and allows faster completion of training, however I could also argue that Australian trained doctors have more well rounded clinical experience in all disciplines prior to specialisation.

The cost of medical education in the USA also deserves a mention. The average US medical school debt in 2016 was estimated to be $189,165 at graduation, however total repayment costs, including accrued interest, range from $273,000 to $406,000 depending on the loan type and repayment time period [3]. Compare this to the much more affordable Australian system, where the average cost for a domestic student eligible for a commonwealth supported place in Australia is $42,000 for a 4-year medical degree due to the government cap on the student’s contribution to fees [4]. HECS-HELP loans are only subject to indexation not interest, so the debt remains at a manageable amount until repaid [4]. At the moment, Australian graduates remain relatively protected from the massive higher education debt burden so common in America.

So what is my overall opinion?

Australia’s health system certainly has some room for improvement. Out of pocket costs for elective surgery in the private sector are escalating. The government Medicare rebate freeze has led to higher out of pocket costs to see a GP as the current rebates are just not enough to keep up with rising health care costs. Health insurance premiums and university costs are climbing while government education funding is expected to decline. We should also be mindful of the implications of training mid-level health care workers in our country and ensure that we have well thought out standards and supervision restrictions in place to avoid the quality of care concerns that America is currently facing. Unless we are careful, we are in essence running the risk of becoming more and more like the American system. Despite these challenges, I certainly have gained a real appreciation for the quality of our healthcare, our free public health system and our government funded tertiary education system. I am far more grateful for what we have after seeing another side.

While the quality of available health care in America is of a high standard, the insurance complexity, cost and access difficulties limit the overall health status of many Americans. As the system often relies on individuals to act as their own advocate and seek access to care unguided, there are subsequent gaps in patient continuity of care. Unless the US government seeks to take on the complex and difficult task of creating a more universal, affordable and more regulated health system for all Americans, I fear the health disparity between the insured and uninsured will only increase. While I am
not optimistic for positive change with the current Trump Administration, I will try to remain hopeful for the sake of all my loved ones in America who are affected.

References


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