A New Development in the Provision of Comprehensive Medical Care in Australia

A Description of the Southern Memorial Hospital, Melbourne, Victoria

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An example is presented of a government-sponsored hospital in Australia working in cooperation with private general practitioners to provide them access to the total hospital facilities and to develop a health center that provides paramedical services not previously available in the community.

Introduction

The provision of comprehensive primary medical care services to families and individuals is of continuing concern to those of us in the field of public health. It is frequently of value to study the solutions to this problem being proposed in other countries to learn what they are doing and what aspects may be applicable to the American situation.

In this article I will discuss a program in the Australian state of Victoria that is providing a comprehensive primary medical care service by including general practitioners on the staff of a public community hospital and through the development of a health center.

Although Australia is not beset to the same extent by the myriad problems confronting those providing medical care services in the United States today, all is not entirely well. The Australian Medical Association Study Group on Medical Planning is aware of a rising demand for health care from the community. They feel "this demand can no longer be satisfied by medical practitioners working in isolation from other members of the health team."[1]

Australian health spokesman Richard Southby states, "General practice is facing serious problems in Australia in terms of declining numbers of practitioners in relation to the population, the recruitment of young medical graduates into this field and the lack of an effective organization of primary medical care services . . . in many instances the general practitioner does not have the necessary supporting services of associated health personnel and voluntary organizations available for his patients."[2]

Southern Memorial is attempting to deal with these problems in a way that is new to Australia.

The Hospital System in Victoria

In order to understand the general practitioner's relationship to metropolitan public hospitals in the state of

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Victoria, it is necessary first to briefly describe the hospital system. There are basically two types of hospitals in Victoria which can be classified according to their main source of revenue:

Public hospitals are primarily supported by funds from the Victorian Hospitals and Charities Commission (VHCC), a state agency set up to distribute federal monies to support a public hospital system and various other charitable institutions. The VHCC does not involve itself in the day to day running of these organizations, but by virtue of granting or not granting monies it does in fact exert considerable influence on all activities of the institution including building, purchase of equipment, and program development.

Private hospitals depend primarily on private fund raising and patient fees to support themselves. The VHCC has little influence on private hospital programs or policies, although it is responsible for registering these hospitals and inspecting them to ensure that basic building and staff requirements are met.

In metropolitan areas such as Melbourne, general practitioners have been almost totally excluded from the medical staffs of public hospitals. This is largely because the public hospitals through the medical school affiliation have become the domain of the consultant (specialist), his complicated and expensive apparatus, and his interest in the treatment of the more esoteric diseases. General practitioners do occasionally serve as clinical assistants in the outpatient clinics of public hospitals working under the direction of a consultant. The general practitioner can refer his patients to the public hospital for evaluation by a consultant but then virtually loses control of and contact with the patient during that period of referral.

General practitioners do admit and take care of patients in private hospitals but 24-hour house staff coverage is generally not available nor is the more sophisticated equipment.

Australia has a government-subsidized voluntary health and medical benefits scheme. Approximately 82 per cent[3] of the population in Victoria is insured and thus considered private patients. Pensioners (primarily retired elderly people) get free care through the Pensioner Medical Service. When hospitalization is necessary they are usually admitted to public hospitals as public patients. As a result of this and other factors, public hospitals tend to have an overabundance of elderly patients with chronic diseases, accident victims, and those patients requiring highly specialized forms of treatment.[4]

Southern Memorial Hospital

In the years after World War II a group of Melbourne citizens requested funds from the VHCC to build a hospital in the suburban community of Caulfield.* As the plans evolved, the Commission, working with general practitioners in the area, took the opportunity to suggest that they develop a public hospital which would incorporate general practitioners on the medical staff. It was intended that they be involved with both in- and outpatient care and hopefully reverse the current trends to exclude general practitioners from public hospitals. It was also felt that the hospital could provide an improved service to all patients by developing a health center to make services of associated health personnel readily available to patients.

In 1969 a 48-bed hospital was opened with the inpatient services of Medicine and Surgery. These are headed by consultants who are paid sessional fees by the hospital and have the right to private practice. Payment of sessional fees is unusual in Melbourne, and generally these positions are honorary and time is donated; however, it was felt that payment of fees would give the hospital board greater control over its staff. Other consultant staff include assistant chiefs of surgery and medicine, anesthesiologists, radiologists, and a pathologist. Currently there are a total of 76 general practitioners on the staff; of these, seven have 3-year appointments, 18 have 2-year appointments, and the rest have 1-year appointments.[6]

When patients are admitted to the hospital they are under the supervision of both a consultant and their own general practitioner. If they do not have a general practitioner one is assigned from the staff. A resident is also assigned to the patient. The general practitioner sends an accompanying admission note with the patient, giving pertinent data with regard to his medical condition including details of the work-up to date and pertinent family and social history. The general practitioner is encouraged to follow the patient in the hospital and meet with the consultant and house officer to discuss the patient's course and plans for therapy. The consultant assumes final responsibility for patient management because of his legal responsibility to the patient and the hospital; however, his resultant relationship with the general practitioner frequently encourages the consultant to discharge the patient earlier to be followed up at home or office by the general practitioner. It also gives the consultant and resident insights into the patient's family and social history of which they may otherwise be unaware.

As soon as the patient is discharged he is given a brief handwritten summary—a copy of which remains on the chart—to give his family doctor on his first visit, which is usually arranged prior to discharge. A more detailed typed summary is sent to the general practitioner shortly after discharge.

Role of the General Practitioner

The issue of general practitioner responsibility for inpatients is one of the biggest question marks for the whole scheme at present. While the general practitioner does not have final responsibility for inpatient care, he takes an interest in the patient while in hospital, coming to visit frequently and thus providing a familiar landmark to

* Much of the following information is from Ref. 5.

the patient in the alien hospital surroundings and assuring the patient of his continuing interest and preparedness to take over his case upon discharge. Close contact with the specialist and staff also provides an opportunity for the general practitioner to keep abreast of all the latest developments in medicine.

The extent of involvement of the general practitioner depends almost entirely on his interest and aggressiveness. As the consultant staff become more confident and aware of each practitioner's areas of competence they permit him to assume more responsibility in the care of inpatients. However, general practitioners are not expected or encouraged to become as knowledgeable as consultants in particular areas. The generalist is coming to realize that his field of expertise lies in his relationship to the patient and his family, and his understanding of the relationship of the patient's social situation to his illness. To emphasize this aspect of their role, the medical staff of Southern Memorial (predominantly general practitioners) voted that generalists not perform surgery at this hospital.

Future plans are for the general practitioners to have their own inpatient beds to which patients could be transferred when the need for consultant services is no longer present. By giving the general practitioner total responsibility for the patient before he is discharged, plans for discharge and continuing care could be made more efficiently since the general practitioner is more likely to be aware of the patient's total needs and home situation than either consultant or house staff.

Family Medicine

Another department, Family Medicine, is currently in operation; this is the outpatient phase of the hospital. It is headed by a general practitioner who is chief of Family Medicine and has equal status to the chiefs of Medicine and Surgery. In actuality the outpatient facility of the hospital (except for consultant clinics) is the existing offices of the general practitioners scattered throughout the community surrounding the hospital. If the generalist wishes to use the diagnostic outpatient facilities of the hospital, he fills out a card detailing his request and giving pertinent medical and social data on the patient. The patient is then directed to the admissions office of the hospital where he obtains a permanent hospital record and number. He then goes for the diagnostic study. The results are sent to hospital records and from there to the patient's chart and to the referring physician. In order to establish some control over use of these facilities, the hospital requires the general practitioner to fill out and return a review slip that gives details on the patient's diagnosis and plans for treatment. These records are subject to peer review audits and failure to return slips satisfactorily is taken into consideration when staff appointments are renewed. Medical audits are the exception rather than the rule in Melbourne and this is one of the first times any aspect of the generalist's private practice has been brought under scrutiny by his peers.

Community Care Center

The second stage in the development of this comprehensive primary care program is a health center called the Community Care Center which has just gotten underway. This will provide outpatient and domiciliary paramedical services. The health workers in the center consist of a social worker, two visiting nurses from the Royal District Nursing Service, a physiotherapist, a dietitian, part-time occupational and speech therapists, a nurse who collects pathology specimens on a domiciliary level, a liaison officer to corrdinate group activities and to relate to the community, and a secretary-receptionist.

This group working with the general practitioners comprises the health team. Currently the general practitioner staff is divided into five groups, with each group assigned to meet with the team members one morning a week with one physician assigned as group leader each day. The five group leaders are paid on a sessional basis for their services. All new inpatients of the participating practitioners are briefly presented by the patient's doctor, who acts as team leader for his patients. If he feels that the services of the other health workers are needed, he can initiate them at the team conference or by written referral. Frequently after discussing the patients with the team, the general practitoner learns new ways in which their services can be beneficial to his patients. Outpatients can also be presented for team services. Review of continuing patients takes place at specified intervals according to individual needs.

Health workers' assessments are recorded on the patient's chart with copies sent to the referring physicians. The health workers moved into a new building on the hospital grounds as of November 27, 1972. Initially it is planned that this health center facility will house general practitioners on a sessional basis 5 days a week seeing their private patients as well as those who present at the center without a physician on the hospital staff. A rostered list of physicians will be available for emergency out-of-hours duty.

This is the first time that many of these ancillary services have been directly availabe for the general practitioner to use for his patients either as outpatients or in the home. It is also the first time that many of these services have been presented in a team approach involving the general practitioner. It is hoped that their presence will result in better care for patients and will lead to more appropriate use of hospital beds.

The health workers find that an advantage of working with the physician while the patient is still hospitalized is that they are able to assess the patient, establish a relationship with him, and initiate therapy prior to his discharge.

Although the Family Medicine program and especially the Community Care Center are still in the developing stage, most participants feel that the program has already had some degree of success.

Advantages of the Program

1. General practitioners are able to use the outpatient facilities of a public hospital without having to refer the patient to a consultant and they can readily follow and keep touch with those patients when hospitalization is needed.

2. Public patients benefit from having access to their family doctor at all times and private patients benefit from the more sophisticated services available.

3. The Community Care Center is providing a wide range of services previously not availabe in the community.

4. The record audit, in addition to serving as a control over use of hospital facilities, serves as a learning experience for the participating practitioners. Close contact with consultants also provides opportunities for keeping up to date in medicine.

5. Resident house staff are being exposed to more common diseases in younger age groups than are generally seen in public hospitals. More importantly, they are being exposed in clinical situations to the general practitioner and to the auxiliary health team worker. There is already some limited medical student involvement in the program and plans are for this exposure to be expanded.

6. The program provides some new career opportunities for general practitioners. There is already a generalist as chief of Family Medicine and there are three levels of generalist staff appointees to the hospital.

7. Finally, the Southern Memorial program does provide a comprehensive primary medical care service to patients of participating practitioners. The general practitioner remains the source of initial contact for the patient, follows him if hospitalization is needed, and provides the access for paramedical and community services.

The Southern Memorial program has been fortunate in starting a new program in a new hospital and also in starting with a small hospital and a limited number of staff to relate to. A building program is currently underway which will eventually bring the hospital to 400-plus beds. Lines of communication which are more formal will have to be established to replace the easy flowing informality that exists in a small organization, particularly with regard to the consultant-general practitioner relationship.

Involving resident house staff in the Community Care Program is currently a problem. The house staff is overwhelmed with routine inpatient duties and have difficulty finding time to meet with the team. There are plans for a Family Medicine resident to be attached to the hospital at the beginning of next year to work in both the inpatient service and the health center.

While it is difficult to suggest direct applications of this program to an entirely different system such as exists in the United States, this program does demonstrate that by involving the patient's personal physician in all aspects of care a successful comprehensive primary medical service can be developed. It also shows that making various paramedical services available in a government-sponsored team-structured health center is acceptable to private practitioners and they are willing to accept the responsibilities and reasonable limitations on their practices in order to participate in the program.

It is important to note that general practitioners were involved in the development of this program from its earliest stages and that the program has evolved slowly but steadily—both factors contributing to its acceptance by physicians and the rest of the community.

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