Abstract

The Australian and Malaysian systems of general practice were examined and compared. The issues of similarity and difference identified are discussed in this paper. Quality clinical practice and the importance of compulsory vocational training prior to entry into general practice and continuing professional development is one important area. A move towards preventive health care and chronic disease management was observed in both countries. Practice incentive programmes to support such initiatives as improved rates of immunisation and cervical smear testing and the implementation of information technology and information management systems need careful implementation. The Medicare system used in Australia may not be appropriate for general practitioners in Malaysia and, if used, a pharmaceutical benefit scheme would also need to be established. In both countries the corporatisation of medical practice is causing concern for the medical profession. Rural and aboriginal health issues remain important in both countries. Graduate medical student entry is an attractive option but workforce requirements mean that medical education will need individual tailoring for each country. Incorporating nurses into primary health care may provide benefits such as cost savings. The integration model of community centres in Malaysia involving doctors, nurses and allied health professionals, such as physiotherapists, in a single location deserves further examination. Asia Pac J Public Health 2002; 14(2): 59-63.

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Primary Health Care and General Practice — a Comparison between Australia and Malaysia

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Introduction

This paper examines the current state of primary health care systems, and especially general practice, in Australia and Malaysia from direct observation and review of the available literature. It is hoped that the issues raised will excite further discussion and sharing of information leading to improvements in both health care systems.

Primary Health Care (PHC), as defined by the World Health Organisation in 1978 at Alma Ata, refers to curative treatment given by first contact health care providers as well as health promotion, preventive care and rehabilitative services provided by multidisciplinary teams of health care professionals working collaboratively. The philosophy of PHC includes the interconnecting principles of equity, access, empowerment, community self-determination and inter-sectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health⁶.

General practice is defined by the Royal Australian College of General Practitioners as that part of medicine which provides initial, continuing, comprehensive and coordinated medical care for all individuals, families and communities and which integrates current biomedical, psychological and social understandings of health⁷.

Australia has developed a PHC agenda that places general practice at the centre of a multidisciplinary team approach to the care of the individuals and populations. Similarly, in Malaysia, public health centres and general practices have been given a pivotal role in health care provision for the population.

In Australia, general practice is viewed largely as being independent, with practices run as small businesses. Most general practitioners' (GPs) income is derived on a fee for service basis⁸. Patients receive a level of reimbursement from the public sector through the Medicare system. Some practices are bulk-billing where the patients do not pay anything for medical services as the practice claims reimbursement directly from the Health Insurance Commission (HIC). The HIC runs as a national health insurance scheme. It provides feedback to GPs about their utilisation of the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme. In Malaysia, both public health centres and private general practices provide primary health care services. Public health centres are relatively free for all citizens, while general practices are private independent businesses. The two systems are meant to be complementary, but in reality, patients may “doctor hop” from one to the
other due to factors such as accessibility, availability, time factors and cost.

Quality

In Malaysia, the quality of general practice delivery has been extremely variable. A medical practitioner can set up practice as a GP with only a basic medical degree. Suggestions were mooted more than ten years ago for all GPs to undergo vocational training\(^5\) but, as there is no legislation to make it mandatory, the response has been very disappointing. On the other hand, three public universities have established Departments of Primary Care Medicine or Family Medicine and have been producing graduates who are called family medicine specialists and who work in public health centres. While the ministry is trying to raise the standard of primary care in the public sector, the private sector is yet to catch up. It is both desirable and essential to make vocational training compulsory prior to entry into general practice to improve the standard of the discipline of general practice in the country.

In Australia, compulsory vocational training for all GPs started ten years ago. At the beginning of this period, GPs with five years of experience were considered as vocationally registered through the 'grandfather' route. This may be a good solution for Malaysia also during a transition period but eventually all GPs should be vocationally trained.

Globally, the importance of continuous professional development (CPD) for all medical practitioners is also recognised. This can be attained through attending scientific seminars, workshops, conferences, internet online continuing medical education (CME) programmes and performing audit in one's practice. In Australia, compulsory CPD every three years is required to maintain vocational registration. This is appealing to patients too as they are able to receive a higher reimbursement if they attend a vocationally trained GP.

In Malaysia, there was a recent announcement by the Ministry of Health that all doctors will soon be required to fulfil a minimum number of credit points under a CME programme in order to renew their annual practising certificate\(^6\). It is definitely time to implement this and it should have been done sooner. Another positive move towards quality improvement in Malaysia will be the accreditation of general practices such as has been initiated in Australia. In the United Kingdom, there is also a new move by the government requiring all doctors to undergo competency checks every five years\(^7\).

In the United States of America family physicians have to sit the certifying board examination every seven years. In Malaysia, suggestions have been made to evaluate the family medicine specialists who staff public health centres. All these are important steps towards improved clinical quality.

Disease patterns

GPs are now dealing with much preventive health care and chronic disease management as well as acute medical care in Australia. This is in part due to the relative affluence of their society. The Enhanced Primary Care Initiative introduced in 1999 within the Medicare Benefits Scheme (MBS) encourages GP involvement in care planning, case conferencing and annual health assessments for all people aged 75 years and over. The Sharing Health Care (chronic disease self-management) programme, which is part of the initiative for people with chronic and complex conditions, aims to improve the health related quality of life for people with chronic diseases, to promote effective use of health care resources and to achieve collaboration between the care professionals, the family and carers\(^8\)\(^9\). These are designed to enhance multidisciplinary teamwork and holistic care through altered funding mechanisms for GPs. Similarly, the Ministry of Health in Malaysia, in the Telehealth Blueprint, has also been orientated towards community health, with extended, shared and home care including self care. The emphasis is placed on health promotion and disease prevention, health risk assessment, empowerment of individuals, and focus on the health of families and communities\(^10\). This can be run in parallel with acute care in general practice.

Practice incentive programmes

In Australia there is a programme of incentives aimed at rewarding quality clinical practice. This comprises five elements: information management, information technology, after-hours care, rural practice, teaching of medical students, and participation in targeted incentive programmes. The targeted incentive programmes to support such initiatives as improved levels of immunisation and cervical smear testing in Australia have been shown to be effective\(^12\)\(^13\). In Malaysia, the immunisation programme has been effective\(^14\) but not so for cervical screening. Although the programme was started 30 years ago by the Ministry of Health, the prevalence of cervical screening is still only 26% according to the 1996 National Health and Morbidity Survey II\(^15\). A better recall system is needed together with more funding to make this programme a success. In the private sector, one of the ways to increase the uptake of health promotion can be by providing tax incentives to those GPs who reach certain targets.

Information technology (IT) and information management (IM)

IT/IM provides many potential benefits to general practice. It can allow efficient work practices, better coordination between health care providers, better data analysis for audits and further opportunities for clinical research. Key barriers identified in Australia include the cost of computerisation, lack of technical training and support, concerns about the confidentiality of medical information and many possible medico-legal issues. Three years ago in Australia, GPs were able to claim government funds towards the purchase of computer systems. A system to support the acquisition of hardware and to encourage computerisation for clinical use has been shown to be an effective way of encouraging participation in IT. The Divisions of General Practice in Australia, which serve to provide programmes to support improvements in patient care in general practice, supplied an information technology
support service for GPs across the country as they computerised their clinics. This has facilitated the computerisation of a majority of practices in Australia. Now the majority of Australia’s GPs use a computer for prescribing and other clinical purposes.

In Malaysia, personal taxation relief of RM 5,000 is given to everyone buying computer hardware. More tax relief could be provided for private GPs to promote computer utilisation for clinical use. Linking laboratory results has been established in some practices that have computers but could be made more widespread if more practices are computerised. In public health centres, computers have been provided to allow word processing, but to date they have not been utilised for central control of data and clinical purposes.

A Smart Card system initiated in Malaysia is an innovation that allows all health information on an individual to be available on one card. However, this needs adequate system backing and software support. In order for such a smart card system to be fully functional, the health system will need to be fully computerised. Such concepts are excellent and are being piloted to anticipate unforeseen problems to ensure smooth implementation. In the interim, general practice should aim for full computerisation. Appropriate tax incentives and tailor-designed software programmes appropriate for primary care in Malaysia need to be developed. Problems of efficient system and software support need to be addressed.

Medicare

Medicare is the national health scheme in Australia. Patients are able to get a rebate from the public purse after using health care services for consultations or procedures. When this system was first implemented in Australia, it was met with some resistance, as General Practice then was private. Such a system might be inappropriate for private GPs in Malaysia at present unless dispensing rights were to be removed from them. As Malaysia has public health centres that cater for the needs of the poor, the present system of public and private primary medical care may continue for some time. Recently, the Ministry of Health has proposed an establishment of a national health financing authority that will integrate the public and private sectors as well as different levels of health care provision. This body will be fully owned by the government and will monitor and evaluate the system. It is timely to have a single agent to facilitate planning and implementation of health care.

Pharmaceutical benefit scheme

This exists in Australia as well as in certain institutions in Malaysia. Many medications have been subsidised by the Australian government, especially for the needy. A control system of authorisation exists for expensive medication where GPs have to justify the prescription of some medications. In order to obtain approval for an expensive prescription, GPs have to telephone the Health Insurance Commission and read out the protocol.

In Malaysia, if dispensing rights were removed from private GPs, a similar system to the pharmaceutical benefit scheme could be established for the needy. However, prescribing behaviour may then change among GPs who may not appreciate health care costs. Protocols may need to be imposed to prevent inappropriate prescribing. Doctors’ prescribing behaviour, quality of prescribing, health care costs, autonomy and prescribing rights of the profession are areas that need further deliberation.

Corporatisation of medical practice

This is causing some concern for the medical profession in both Australia and Malaysia. In Australia corporate groups buying a general practice may not receive immediate direct financial benefit but they can make this up from the vertical use of other health services they provide such as pathology, radiology and referrals to specialist services within their corporation. In Malaysia corporate groups have been buying into profitable practices and giving the practices shares in the corporate structures. Some people worry about whether the standard of patient care and the access of poorer patients to health care might be compromised if such a practice is implemented nationwide. In Malaysia it is unlikely that the health system will move to full corporatisation as access to health care would then certainly impinge on poorer groups in society. If large scale corporatisation ever occurs in Malaysia, the corporate structures, standards of patient care, patient access to health care and health care costing will all need careful planning. The corporate model currently under development in Malaysia seems to be a more workable model than that being developed in Australia.

Education

Four of the eleven medical schools in Australia have now started graduate medical student entry schemes where the medical students have completed an undergraduate degree prior to entry into medical school. Students seeking selection to a medical course sit screening examinations and attend structured interviews. The length of these new medical courses has been shortened to four years instead of the previous five or six years. One university has a mixed student intake, with those who enter straight from high school taking a six year undergraduate course and those entering the graduate medical system a shorter course. The graduate entry programmes are designed to attract students who are more mature in their thinking and in their approach to clinical problems. However, in Malaysia, manpower for the medical workforce is still deficient. Less than ten institutions, public and private, are offering medical courses. Therefore, the conduct of medical student selection is currently very much dependent on each individual country’s needs and requirements.

Rural issues

Rural general practice and training for rural practice have been issues that have generated much debate in Australia. Issues include longer working hours in many rural areas with an imbalance in remuneration,
and different patterns of workload with often more acute care and obstetric care requiring different skills and hence different training. New training initiatives and a new college for rural medicine have been developed in recent years as a result. Postgraduate training for rural medicine is now four years with three years of GP vocational training and one year of advance rural training. Another problem has been the difficulty in attracting doctors to work in rural areas.

Rural health care has long been a priority area in Malaysia’s health care plan. Malaysia has trained more people from rural areas and within rural areas in the hope that they will continue serving their local communities in the future. This step has now also been taken by Australia. During medical school training in both countries, students have rural training experience as part of their curriculum.

Another measure to increase the medical workforce in rural areas in Malaysia is to send doctors in training to serve rural populations during the three years of compulsory public service with the government following graduation from medical school. This is said to be an interim measure until an adequate rural medical workforce is attained.

Practice nurses

Nurses can certainly be important members of a primary health care team. A move towards incorporating more nursing input in primary health care could provide cost savings and improved outcomes for patients. In primary health centres in Malaysia, medical assistants work as nurse practitioners. Reimbursements or taxation relief could encourage the employment of more practice nurses in private general practices. In Australia, there is government initiative providing general practices with financial support towards the employment of practice nurses.

Aboriginal health

Aboriginal Community Controlled Health Services (ACCHSS) are culturally appropriate, autonomous primary health services initiated, planned and governed by local Aboriginal communities through their elected Aboriginal board of directors. It is a unique model of primary health care and the service is exclusive for aborigines to access health. It is a one-stop centre providing multi-disciplinary care. The benefits of a strong ACCHSSs are being demonstrated through health gains such as improvements in immunisation rates and reduction in sexually transmitted disease rates. As aboriginal people have much higher rates of morbidity and mortality in Australia when compared to the rest of the population, strategies have been developed or implemented to address a range of chronic, acute and infectious conditions that encompass at least six specific health issues e.g. sexual health, child bearing, immunisation, eye health, social and emotional health, diabetes mellitus and renal disease. The aborigines in Malaysia have higher maternal morbidity and mortality, higher infant mortality rate and lower life expectancy. The health problems faced include infectious diseases such as tuberculosis and malaria, malnutrition, epidemics, intestinal infestations and psychological stresses. Their health care has been catered for by the public health system including mobile team, health centres and flying doctors service in some remote areas. The emphasis of government medical services are on community education, maternal and child health, control of communicable diseases, environmental sanitation, improvement of curative service and referral system and health statistics gathering. In both countries, data on aboriginal health are lacking and the introduction of annual service activity reports for aboriginal primary health care services in Australia is good as it provides basis for services accountability, identifies resource gaps and areas of strategic importance, and supports continuing quality enhancement.

Integration

General practice could function as a one-stop community centre by integrating the resources and manpower available in community centres such as district nurses, physiotherapists and dental health professionals. This is the model provided in the Malaysian public health centres. This enables a better use of resources and avoids duplication of services. General practice can learn some valuable lessons from public health centres, and the reverse is also true.

Conclusion

There are many challenges that lie ahead for primary health care and general practices in both countries. The provision of quality clinical practice through compulsory vocational registration and continuous CPD is essential especially for Malaysia. The enhanced primary care initiatives carried out in both countries need continuous evaluation for effective clinical practice based on best available evidence. Information technology and information management are essential in this era for efficient work. Education of undergraduates as well as registrars in general practice needs to be tailored to individual countries needs. Integration of team work in general practice and improving aboriginal health access and indicators are important goals to target for. With the continuous review of each health care system and ongoing programs of reforms, it is hoped that there will be equitable and affordable health care provision available to all people of both countries.

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