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Condition critical: Where two-tier hospitals are failing Australia's

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BRISBANE, Australia - When free-market critics of Canada's struggling medicare system start to talk of reform, they look to countries like Australia. Canadians, they say, have become wedded to a system that no other major country has, one in which core medical care is funded by a government monopoly.

William Orovan, head of the Ontario Medical Association, made the case a little over a year ago. Why not take a lesson from the rest of the world, he asked them, and allow private hospitals and other forms of private medicine to exist alongside medicare? Sure, the result would be two-tier. But letting those who can afford it pay extra for health services would reduce medicare waiting lists and take pressure off the public system. And while many Canadians fear that the re-introduction of private medicine would lead inexorably to the horrors of the U.S. system, critics say that's fear-mongering. "My only fear is that we will not make progress because we're afraid of an American-style two-tier or multi-tier system," Orovan said. "There are many countries in the world, like Australia and New Zealand, who do things differently."

In Alberta, Premier Ralph Klein is forging ahead with private medicine. In Ontario, Premier Mike Harris is sympathetic. If governments aren't willing to put more public money into basic health, he said last month, the only sensible alternative is to tap the private sector. Would that really be the end of the world?

To try and answer these questions, The Star took a close look at the Australian medicare system. It's a system much like Canada's - in fact, it was modelled on ours. But unlike this country, Australia allows - even encourages - private hospitals and insurers to operate alongside the public system. If Canada were to add a private tier to its health care system, along the lines suggested by the OMA or the Reform Party, it would probably end up with one almost identical to Australia's. In Australia, every resident may use the public medicare system where all, or nearly all, the costs are picked up by the government. But those who wish can also pay extra to be treated privately. They can avoid long waiting lists by using private hospitals (about one-third of Australia's 1,100 acute care hospitals are private). And they can buy private health insurance - not just for ancillary services like dental care, as in Canada, but full-blown medical insurance that will cover them for anything, including procedures as complex as brain surgery.

During a month in Australia, I talked to nurses, doctors, politicians, health experts and just plain patients. I visited crowded public hospitals which, like their Canadian counterparts, are trying to cope with years of government cutbacks. And I toured private hospitals so spanking new, they seemed four-star hotels. What I found was not an unalloyed horror story. Two-tier medicine has not destroyed Australia's public medicare system, at least not yet. Australia is not the U.S., where only the well-to-do get good care and the middle classes have to scramble. But at the same time, private medicine has not been without cost. By diverting resources, it has weakened the public system - some say fatally. Certainly, it has not produced the benefits claimed by its Canadian adherents. In particular: It has not eased pressure on the public system; in fact, it has made waiting lists in the public hospitals longer. It has not saved money.

Hospital privatization schemes, along the lines suggested by Alberta's Klein, have been financial disasters. More tellingly, two-tier health care has actually cost more money. In Australia, the federal government has been forced to subsidize the private health industry, to the tune of \$2.2 billion a year, just to keep it alive.

Ironically, the real success story in the Australian health system - both financially and medically - has not been private medicine. It has been pharmacare, a universal, publicly-funded drug benefit program.

To an outsider, this seems an exceedingly curious free market solution. Just north of Brisbane, in the town of Caboolture, 20-year-old Eileen McLean is explaining the peculiarities, as she sees them, of Australia's hybrid system. McLean has an unusual condition for such a young person: she has cataracts, an eye condition that impairs her sight. If she were to get them removed in a public hospital, she wouldn't incur any out-of-pocket costs. But she would face an 18-month wait.

"I can't wait that long," she explains. "I can't drive. And I have to go back to school." So McLean "went private." She arranged with her eye surgeon to do the operation outside of medicare. The wait will be only four weeks and the cost - to her - will be \$900.

What's peculiar is that she is getting the fast-track private surgery from the same doctor who would have made her wait 18 months, had she used his services through the public system. And she's getting it done in the same public hospital. Same doctor. Same equipment. Same operating room. The only difference is that her eye surgeon is getting paid \$900 more than he would have under medicare. In effect, McLean is being held to ransom. She is being forced to pay extra for treatment that by rights she should get under medicare.

Almost everyone in Australia who has dealt with the health system has a similar story. Dr. Tracy Schrader, a Brisbane physician, recalls the time her 54-year-old father experienced serious heart problems. "He saw a cardiologist who said 'You can wait six months and get an operation in the public system or I'll do it for you tomorrow privately.'

"My father was in a panic; he was out getting bank loans to raise the money. And he was in bad way. He couldn't work. He couldn't even walk."

His experience, and that of Eileen McLean, points to one of the fundamental weaknesses of the two-tier system: While there may be two tiers of health care, there is only one set of physicians. And these physicians - particularly in high-demand specialities - are free to arrange their time between the private and public systems as they see fit. An orthopedic surgeon, for example, may have a contract to work at a public hospital. But he will also see his own private patients separately. And he may operate on these private patients either at the public institution or, more commonly, at a private hospital.

For a relatively straightforward elective procedure such as knee surgery, he will usually prefer to channel his patients into the private system. There, unlike the public medicare system, he can charge whatever the market will bear. Yet the more these specialists work in the private tier, the less time they have to work in the public - and the longer the public waiting lists get.

As Jeff Richardson, a health economist at Melbourne's Monash University explains, this has created a perverse result: a government that encourages the private health system in order to reduce public waiting lists may end up making them longer. Even the head of the Australian Medical Association, an organization that firmly supports private medicine, agrees. "Most doctors see working in the public system as altruism," says Dr. David Brand. "They are altruistic. "But it is true - the more incentives you have in the private sector, the more you pull doctors across to it."

Newer private hospitals, such as Sydney's North Shore Private, in the posh northern suburbs of the city, have set themselves up explicitly to take advantage of this dynamic. In Australia, the most prestigious hospitals - the so-called teaching hospitals, where the sexiest and most adventurous medicine takes place - are virtually all public. In North Sydney, for example, the big public teaching hospital is Royal North Shore. To take advantage of Royal's staff and state-of-the-art equipment, North Shore Private set itself up right next door. It offered Royal's roster of specialists luxurious offices in its brand new building, and encouraged them to do their elective surgery - at top dollar - in its brand new operating rooms. It even built an overhead covered bridge to connect the two institutions so that, if it rains, the specialists don't get wet as they go back and forth.

But if Australian policy makers had hoped that North Shore Private would take some of the load off the adjoining public hospital, they were wrong. "There was some fear that we'd steal business from the public hospital," says North Shore Private's director of clinical services, Catherine Lambert. "But no. About 92 per cent of our patients are in for elective surgery. And even of those, we've taken very few from Royal North Shore. Most seem to have come from other, smaller private hospitals in the area."

Unlike most private hospitals, which concentrate on relatively simple procedures, North Shore Private prides itself on doing high-status cardiac and neurosurgical operations. A cardiac bypass operation, for example, will earn the hospital about \$25,000 to \$30,000 from the patient. On top of this, the surgical team of doctors will probably get from \$15,000 to \$20,000. A patient who chooses to have his bypass done at North Shore Private rather than Royal North Shore Public will get some of the doctors' fees back from medicare. His private insurance, if he has it, may cover another portion of the physicians' fees as well as part, or in a few cases all, of the hospital

fees. But, says Lambert, the patient will almost surely have to pay an additional \$2,000 to \$6,000 out of his pocket to cover that portion of the physicians' fees that are not picked up by any insurance.

Why would anyone pay all of that - private insurance premiums plus extra top-ups totalling thousands of dollars - when he could have had the same doctor perform the same operation in a state-of-the-art public hospital next door? Aside from North Shore Private's luxury rooms (decorated in tasteful earth tones and containing oversize showers), the answer, says Lambert, is convenience. Patients wanting elective surgery at Royal North Shore may have to wait weeks to see a specialist at the hospital's outpatient clinic, and then perhaps months to have the operation itself. But the same specialists will be happy to see these same patients immediately - as long as they're willing to walk across the bridge and pay a few thousand more.

When people here are told that some Canadians, like Alberta's Klein, are looking to copy Australia's hybrid system, they are at the very least bemused. "How strange," says AMA chief Brand. "We copied our system from you, and now you're looking to us?"

"Why on earth would you change what you've got; it sounds much better than ours," says Robyn Green, a Brisbaneite who has had some rough experiences with her own country's health system.

"Don't do it," says University of Sydney health economist Gavin Mooney. "I would argue very strongly against Canada going down our path." Most experts here say that the hybrid public-private Australian system - with jurisdiction divided between state and federal governments - is neither particularly efficient nor fair. Even supporters of private medicine say that Australia's two-tier system doesn't work very well.

"If I was going to invent a system that was efficient, I wouldn't invent the Australian system," says the AMA's Brand. "The system is crazy. But it protects us (doctors)."

John O'Dea, the AMA's director of medical practices is equally blunt. While he firmly supports two-tier medicine, he himself buys private health insurance only to win a tax break. "I have no intention of using it. . . . There's no good reason to go to a private hospital."

Why then have the parallel private system? "To put it crudely," answers O'Dea, "doctors get paid more in private hospitals. . . . You can earn a lot more by billing the patient than by negotiating with the government."

Yet while specialists can make a good living from the private system, the private hospital companies themselves are not doing well. Profits are down; share prices are plummeting. Ian Chalmers, executive director of the Australian Private Hospitals Association, says that his members are squeezed between a public unwilling to pay the high costs of private medicine and a health insurance industry trying to ratchet down costs.

As for the private insurers, they are making money now but only because the government is, in effect, subsidizing them. In late 1998, the federal Liberal-National government, a conservative coalition, passed legislation giving any Australian with private health insurance a tax rebate

equal to 30 per cent of any premiums paid. The rebate is expected to cost the national treasury a staggering \$2.2 billion this year.

Still, the idea of two-tier medicine remains remarkably popular in the country. Only 30 per cent of the population takes part in the private system; with premiums running at about \$1,500 for the average family, it is too expensive for most. Yet even those who don't earn much seem to like the idea of the private alternative.

Margaret Wakely, for instance, works part-time in a restaurant in Newcastle, a few hours north of Sydney. When I met her last month, she was part of a team of pickets, protesting the privatization of Newcastle's Mater Hospital. Wakely talked about the importance of keeping hospitals like the Mater in public hands. But when the topic of private health came up, she was equally adamant. People who can afford to pay for private insurance have a social duty to take it out, she said. "If we all said we're not paying for private health, well then (the public system) would cost too much. We can't afford it as it is."

Wakely herself has private health insurance. Except for the birth of one of her children, she has never used it. "But what would happen if I got in a car accident?" In fact, if she got in a car accident, according to David Brand, she'd be wise to go to a public hospital. "I'd probably be happier going to a public hospital if I were in a major accident," says the AMA head. "They're used to doing it."

The same point is made by almost everyone familiar with the health system. "I'd never advise anyone to use a private hospital when they're ill," says Dr. David Henry, head of clinical pharmacology at Newcastle's Mater Hospital, a public institution. For one thing, most private hospitals don't have doctors on duty at night or weekends. "Patients are sent here (to Mater) on weekends from local private hospitals because the doctors are off-duty," says Henry.

Most private hospitals don't have emergency rooms; those which do, explains Tracy Pilatti, a public relations spokeswoman for the country's largest private hospital chain, Health Care of Australia, rarely make money on them, preferring to use them as loss leaders that will draw in new business. Even the more sophisticated private hospitals are reluctant to take up the burden of Australia's overcrowded public emergency rooms.

Gavin O'Meara, general manager of Greenslopes Private Hospital in Brisbane, says that if he had to choose between closing his money-losing emergency room for a day or postponing lucrative elective surgery, he would not hesitate. "I'd shut the emergency . . . it's our business if we do that, not the government's."

Yet many Australians firmly believe - contrary to all evidence - that medical care is better in the private system. Robyn Green says her health was ruined by a privately-paid specialist performing what was supposed to be a routine gynecological operation in a private hospital, an operation which left her with masses of internal scars called adhesions, and in chronic pain. Even so - and even though she has been unemployed for seven years - she still scrapes together enough to pay her private health insurance premiums. Asked why, she appears surprised that anyone would ask. "The public system's much worse," she says. "It must be. It's free."