

Australia's private health care disaster

Hamilton Spectator and Straight Goods – March 23, 2002

By Dr. Gordon Guyatt

Alex Barratt's brother -- we'll call him Bill -- had a sore, swollen knee. His family doctor said "You need some intravenous antibiotics". She gave him a letter to the doctors at the emergency ward of the local hospital in Sydney, Australia, where Bill lives. The hospital, a teaching hospital associated with the university, primarily serves patients without private insurance.

At the emergency ward, the doctor ignored the letter from the family doctor, and four hours later, Bill was admitted to hospital. He had not yet received pain relief or antibiotics. Two days later he was in a ward, but still no intravenous antibiotics because the orthopaedic consultant on duty hadn't got around to seeing him.

At this point, he cracked. "OK," he said to the one overworked nurse he could find, who hadn't had enough time to answer his calls even once over the last 36 hours, "I want to go to the private ward." So they re-admitted him as a private patient and transferred him to the private hospital that now forms about half the wards of the previously entirely public hospital.

In the private hospital that was opened about four years ago, Bill had his own room instead of his own bed in an 8-bed ward. He had a window with a spectacular view of the city, which he could see because the windows had actually been cleaned in living memory. He had a nurse who appeared within seconds of his buzzing. Unlike the public ward, this ward was clean, freshly painted and brightly lit. And, within a couple of hours of transfer, a doctor ordered his intravenous antibiotics.

The same thing is happening all over Australia. Formerly prestigious public teaching hospitals are building on-site private hospitals and there is an increasingly obvious gap in health service between the two systems.

Bill's sister, Australian health researcher Alex Barratt, told me his story. Dr. Barratt notes that her brother's story is not unique or bad luck. She has heard similar stories from many people. Public hospitals are

challenged by understaffing, decaying buildings and long waiting lists for much elective surgery, in particular orthopedic procedures.

Australia's health care story reads like a nightmare vision of Canada's future. In 1972, Australian Prime Minister Gough Whitlam introduced Australia's first universal health care system, the equivalent of our Medicare. The new system worked well, and the hospitals were well funded. There were a few private hospitals providing minor surgical services. But Dr. Barratt told me that until the last few years, if she had been seriously ill she would have chosen to attend a public hospital that had the best expertise and equipment. Now, however, like about 40% of Australians and almost all doctors, Dr. Barratt has private health insurance. Now, with the rise of private hospitals and the deterioration of the public system, she would seek care for a serious illness in a private hospital.

The Australian government, in encouraging development of the private system, argues that the private funds leave more money for maintaining public health care. The mounting problems of hospitals serving the Australian uninsured show the terrible error of that logic. The way to improve public health care is to increase the resources available to the public system.

Australia's experience is not unique. The United States has the most well-developed and highly funded private health care in the industrialized world. Yet, primary care for the uninsured is completely inadequate, and American public hospitals deliver care that is far poorer than we, as Canadians, can expect.

I recently returned from a trip to Chile, where I was teaching in both public and private hospitals, and spoke to many doctors working in both systems. Before the 1973 coup that brought Augusto Pinochet's military dictatorship to power, Chile had a strong public health care system. Pinochet's policies led to major expansion of private, multi-tiered health care, and the deterioration of public hospital care.

Why does the development of a parallel private system mean the end, rather than the salvation, of universal high-quality health care? People are much more willing to pay for services they themselves receive, rather than services for other people. In Canada, the middle class and the wealthy

receive the same physician and hospital care as do the poor. Thus, whatever our income, our tax dollars maintain a health care system from which we ourselves benefit.

The recent deterioration of our public school system, and the flight of the middle class from public to private schools in Ontario, shows what happens when the more affluent have an escape valve from the public system. The cutbacks in social welfare programs demonstrate our increasing reluctance to commit our tax dollars for the benefit of others. When the affluent no longer have a personal stake in public health care, resources devoted to public care decrease. The way the Australian public health care system has deteriorated as the private system has grown is a vivid example of the same phenomenon.

The Australian experience offers clear lessons. Private dollars cannot save public health care. Any step we take toward two-tier care is at our peril.