

Laser Surgery Shows How Private Health Care Robs the Public System

By Dr. Gordon Guyatt

(The article below, with some minor differences, appeared in the Hamilton Spectator, March 19, 2001)

Specialist eye care is getting harder to come by.

Dr. Mark Quigg, a Collingwood primary care doctor, has largely given up trying to obtain specialist eye care for patients with non-urgent problems. He is now treating conditions that, in the past, he would have referred to an ophthalmologist. He hopes his patients are still getting top quality care, but he knows that he doesn't have the advanced training of the specialist.

The story is the same in large urban centres. Waiting lists for regular eye care from specialists have become intolerable. Family physicians have to rely on optometrists to persuade the specialist ophthalmologists to squeeze patients in to their crowded schedules.

There are a number of reasons for the problem, including the aging population older folks are most in need of specialist eye care. But another important cause is that ophthalmologists are being increasingly drawn in to the practice of laser surgery. The procedure, which changes the shape of the cornea so patients may no longer need glasses or contact lenses, has enjoyed an explosion in popularity.

Over 1 million procedures were done in the United States last year, and up to 100,000 in Canada. That's a lot of work for the eye surgeons.

This bad situation is likely to get worse. Reporting on a survey of Ontario ophthalmologists in the Ontario Medical Review in May 2000, the authors concluded, "Approximately twice as many ophthalmologists will be performing excimer refractive surgery (laser surgery) in 2005. This will result in fewer ophthalmologists to perform emergency procedures, as well as longer waiting lists."

Why would eye specialists reduce the time they spend dealing with more pressing patient problems, sometimes turning to full time laser surgery?

The answer is not complicated: money.

Up until recent price wars, the standard fee for each eye was \$2,000. Of the \$2,000, the eye surgeon would typically receive \$300 or more. Rates have fallen, and current reimbursement is more typically \$150 per eye. But since the procedure takes approximately 10 minutes, it remains a very efficient money-maker.

Physicians may be tempted to abandon treating serious medical problems in the public system wherever there is a private market promising a higher income. Some plastic surgeons have, for instance, stopped looking after patients with serious burns, or patients with cancer. Instead, they spend their time on better paying cosmetic surgery.

Are there ethical problems with these decisions? Some would argue that medicine imposes a stronger obligation for public service than other professions. If so, perhaps physicians have a duty to deliver care to patients who need it most. Considering that the public pays most of the cost of a doctor's medical training may further strengthen that duty.

Unfortunately, arguing their moral obligations is unlikely to draw laser eye surgeons, or plastic surgeons, back into the public system. Are there other possible solutions?

One strategy would be to penalize physicians who leave specialties where there are doctor shortages, such as ophthalmology, for money-making private activities. Penalties could include exclusion from any public reimbursement (a strategy Quebec has already adopted), a demand to repay the money the public spent on their medical education, or a surtax on profits for delivery of private medical care..

Alternatively, legislation might control the charges that doctors could levy for private medical procedures, reducing the incentive to leave the system.

These solutions are unlikely to be politically acceptable, and some may be open to legal challenge. An alternative would be to extend public insurance to cover procedures like laser surgery. Once the procedure is covered by OHIP, the government could negotiate lower fees for laser surgery in relation to assessment and treatment for more important eye

problems.

Public insurance does not currently cover even ordinary glasses. Coverage for glasses would likely have to come before coverage for laser surgery. Including laser surgery in our public plan, while offering the best solution to the problems of for-profit delivery of eye care, is therefore not a likely solution in the near future.

In this column two weeks ago, I pointed out that laser surgery advertising ignores the risks of the procedure, and often gives the impression that every patient can expect 20/20 vision. The second problem that laser surgery highlights is how for-profit medicine sucks resources from the public health care system.

How can we prevent the problems of laser surgery from spreading to other areas of health care? Governments should insist on maintaining all currently insured services, and where possible extend those services. When we hear proposals for moving toward privatized health care, we should remember the lessons of laser surgery.