

Australian healthcare: perspectives of an immigrant from the UK

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Despite it being confusing, inherently inequitable, and subject to excessive federal government control, Australia provides good healthcare

My career has spanned three decades, two of these as a specialist oncologist, and I have been directly involved in delivering healthcare at a variety of levels on three continents. Over the years, I have been the sometimes innocent, but often active, participant in innumerable healthcare changes. Many resulted in outcome improvements. However, on balance, I believe there have been far too many changes in the organisation of the systems of care, not all of which have been for the better.

Examples of this include internal markets being developed and then partially removed in the British National Health Service (NHS) because of inequalities in funding and access; and here, in Victoria, the governance structure affecting the Alfred Hospital where I worked changing four times from 1992–2003, returning eventually almost to the second-generation format.

One of my blessings has been direct experience of working and observing in four diverse social and medical cultures: Edinburgh (somewhat pretentious and aloof), Houston, Texas (brash and pushy), Melbourne (relatively conservative) and Glasgow (friendly, but impoverished). My roles in healthcare have included scrubbing surgeons' boots, in an era when the average length of stay after a myocardial infarction was four weeks and surgeons did not clean their own clogs. Highlights have been working with dedicated clinicians (doctors, nurses and other healthcare professionals), patients and others to deliver, improve, manage and otherwise organise patient-centred care.

My personal philosophy of healthcare was moulded and refined by observing, as a child, a "Dr Finlay-type" family general practitioner in a fledgling NHS and by "salt of the earth" working-class parents. They raised me not in poverty, but in a Scots "but 'n ben" (a two-room house common to many families in postwar Britain) where there could be no savings or excess — and certainly no money for "choice" of education or healthcare. But then, in 1950s and 1960s Britain, there was no need for choice, as both were good and often excellent. That personal ethos has also been honed and influenced by mentors to whom I owe a great deal. They include teachers at Edinburgh Medical School, and in hospitals in Houston, Texas and, in the last decade, in Australia.

Encountering Australia's healthcare system

With that background, for which I give thanks and make no apologies, I embarked in 1992 on the most exciting part of my career — emigration to Melbourne, Victoria. The difference at that time between the NHS — showing its age and beginning to reel from the dogmatic attacks of Mrs Thatcher — and Australia's complex healthcare system was profound.

For a start, Australia is not an offshoot of the "old country". It is foreign. The light is different, and even the hospital buildings seemed brighter and lighter than the soot-begrimed heritage collection that

still makes up much of the NHS estate. Of course, a close inspection of Australia's younger hospitals reveals the inevitable flaws, cracks and problems. However, to be asked to direct a new radiation oncology centre, the William Buckland Radiotherapy Centre at The Alfred in Melbourne, kitted out with the best equipment of the times, and with space and an ambience to please both patients and staff, was an opportunity that had to be grasped and enjoyed.

The challenge permitted me to show that a public hospital such as The Alfred in Melbourne could house a facility the equal in appearance and service quality to any private hospital. Somewhat curiously, there were some in the profession who disapproved. An initial impression of those early days was that some clinicians and many patients felt the public system was for the indigent; that facilities should reflect that; and that the process of care — public clinics, denial of any right to see a particular clinician — should also emphasise the difference. My background would not allow me to concede that. The team I was fortunate to gather and mentor at The Alfred proved over and over (if proof were needed) that quality care could be delivered in the public system and be the equal of that in the private system.

It seemed to me, in 1992, that some clinicians believed they were still "honorarys", donating their time and skills to those who could not afford to see them in private. Yet any observer would not take long to realise that that "private" system was underpinned and subsidised significantly by the federal health service's Medicare system.

The mysteries of Medicare

Medicare confused me from Day 1. When, in early 1992, I innocently asked a committee of Victoria's healthcare service managers and senior clinicians (who were intent on yet another review of radiotherapy services) to explain Medicare, I was regaled with laughter. Eleven years on, as I departed, it was patently clear that neither the press, nor television journalists, nor politicians of any hue, understand Medicare. Clinicians who bill the Medicare Benefits Schedule (MBS), however, do know it in infinite detail, because they need to.

That media and politicians debate as though Medicare only applies to general practice is nonsensical. Argument centred on bulk billing belittles the complex and essential nature of the Australian "NHS".

Because Medicare is misunderstood by patients, media, politicians, government and public servants, healthcare managers at all levels have been able to play the game of cost shifting. It appears to be enjoyed by both federal and state officials and public servants and their ministers and shadow ministers. Add hospital managers to that equation and the situation is ripe for confusion and gamesmanship. Is it reasonable to manage a multibillion-dollar healthcare system on the basis of confusion and shifting costs, often in breach of the Act governing it? Healthcare professionals in Australia have to adapt to this confusing conspiracy. Usually this is done for the benefit of patients. Otherwise, the built-in inequity of the Australian systems would be more obvious to all, and hence presumably less acceptable.

Such inequity is confusing to a newly arrived migrant, particularly one brought up to believe that healthcare should and can be delivered free at the point of care on the basis of need. In addition, is Australia not renowned for being classless and for mateship? The financial

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contribution of patients in Australia to their healthcare is significant and does not clearly and fairly take into account their ability to pay. It is also the secret part of the cost/payment equation. It is rarely quantified in easily available public information, although the Australian Institute of Health and Welfare and the Health Insurance Commission do publish reports on out-of-pocket costs for healthcare. Legislation over recent years to cajole citizens into private health insurance has increased that contribution. It can also be argued that the federal subsidy that supports private health insurance contributions compensates for this increased personal copayment.

It appears that, politically, on both sides of the House, Medicare cannot be dismantled. Compulsion by carrots (the 30% subsidy on insurance premiums) and sticks (increased Medicare levy for those who refuse to be insured) gives money to the private insurers. It is to be hoped that the previously reported ludicrous use of subsidised private health insurance to fund lifestyle improvements (with compact discs and suchlike for the overly stressed) have ceased. The health insurance industry's policies are, however, themselves overly complex and confusing and far from ideal, constrained as the insurers are by legislation as to what is insurable.

Two systems, two tiers

The premium subsidy will rise relentlessly because premiums will rise relentlessly. That subsidy is not available to improve the public hospitals. With two health systems managed by the state and federal governments the process of healthcare management and improvement is not joined up. The result is two systems offering two tiers of care.

To access the "top", or private, tier a patient must generally pay — insurance, "gap" contribution, and over-gap charges. By exercising that much-vaunted "choice", the patient who can elect and who can pay may not be choosing a better outcome. He or she may only be choosing a better place or a more convenient time. While these may be the drivers of such choice, those who cannot so choose should, in my view, not be penalised by needing to rely on underfunded services.

There is, I believe, no inherent or ethical problem with exercising such a choice. The problems I had with the systems were the inbuilt unfairness of one arm of government manipulating the situation at so many levels. The federal government decides on the major subsidy to each state for, *inter alia*, healthcare. It also legislates over private health insurance — not only what can be covered, but also how the people may be persuaded to buy it. In addition, that same government manages a significant double subsidy for private healthcare — the insurance premium subsidy and MBS fees. One result is that those too poor to afford insurance or gap payments rely on a public system which has been progressively underfunded and too often denigrated. One proof of underfunding is the significant waiting times in the public system compared with those in the private system.

The bright side

In spite of these challenges and differences and inequities, the public sector, at least in cancer care in most of Victoria, was good. It was possible to deliver personal, patient-centred care of the highest quality and with the latest technology. It was pleasing to see patients return to a public hospital that had access to a new, but expensive, cytotoxic drug before that drug received a PBS subsidy. Of course, the reverse occurred when that subsidy was approved. It was sad when the public hospital budget ran dry and public patients had to scrimp and save for the same drug in the private sector. Fortunately, recent pilot changes

to this unfair categorisation of and access to expensive drugs will address this inequity. The driver for this was pressure from oncologists, particularly in Victoria and its Cancer Council and the Victorian Cooperative Oncology Group, and it resulted in a pilot study that allowed some public hospitals like The Alfred to prescribe medication to outpatients and, on discharge, on the PBS.

It was also a privilege to work closely with inspired and dedicated colleagues in the "private" sector who established patient-centred services with full support personnel and multidisciplinary-team care. Medicare could not fund that directly in the private sector. The public sector hospitals led the way and did fund, for example, breast care nurses. Enlightened practitioners in private practice followed suit at their own expense.

Now, a year after returning to the real NHS, I recognise that the complex, blurry-edged, two-level system that is Australian healthcare delivers, one way or another, high-quality care to most patients. I still do not think it is equitable or totally fair, but, for the time being, the standard of care is better than much that is available in the UK.

Perhaps it is because the UK system has fallen behind badly that, across Britain, there is an enormous critical reappraisal of the service at all levels. Modernisation agencies, targets, extra funding — even a cancer "czar" and "czarina" — have found their way into a creaking system. It seemed to me that, until very recently, Australia has been slow to ask questions beyond the large political issue of Medicare — bulk billing. Perhaps a glow of self-satisfaction tinged the healthcare community. There also seemed to be a reluctance to rock the boat of subsidised private medicine. Yet, in recent months there has been a healthy questioning in the medical community^{1,2} and medical press,^{3,4} matched by reasoned critiques in the press.^{5,6} Sadly, the federal government's response is akin to Hollywood's approach to the movies, and so we had "MedicarePlus" then "Strengthening Medicare" — or is it just Medicare II? At least the debate continues, if somewhat quietly. I hope that debate will not go silent once the new Medicare has been dragged through Parliament. The issues of equity, quality and cost of care have not yet been fully addressed.

The Australian healthcare system is good. It offered me the opportunity to learn much, from both patients and colleagues. It allowed me to practise good medicine with a superb team in an excellent environment. This good system can still be improved for everyone, if the issues of intergovernmental argument over an unnecessarily duplex, but two-tiered, system could be resolved.

Competing interests

None identified.

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(Received 19 Apr 2004, accepted 17 Jun 2004)

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