

# Australia's Two-Tier Health Care System United Against COVID-19

Bishoy Hanna,<sup>1,2,3</sup> Amanda Chung<sup>4,5,6,7,8</sup>

<sup>1</sup>North Shore Urology Research Group, St Leonards, Australia, <sup>2</sup>Nepean Urology Research Group, Kingswood, Australia, <sup>3</sup>Northern Sydney Local Health District, St Leonards, Australia <sup>4</sup>Department of Urology, Macquarie University Hospital, Macquarie University, Australia, <sup>5</sup>The University of Sydney, Concord Repatriation General Hospital, Department of Urology, Concord, Australia, <sup>6</sup>Department of Urology, Royal North Shore Hospital, St Leonards, Australia, <sup>7</sup>Department of Urology, Northern Beaches Hospital, Frenchs Forest, Australia, <sup>8</sup>Department of Urology, Sydney Adventist Hospital, Wahroonga, Australia

Soc Int Urol J. 2020;1(1):4–5

## Introduction

The coronavirus disease 2019 (COVID-19) pandemic has had and continues to have an unprecedented impact on health care systems worldwide. The Australian system has yet to be truly tested by the pandemic, as rapid implementation of public health measures has curbed infection rates. Australia's 2-tier health care has allowed sufficient staffing, equipment, and beds to continue providing acute health care in the face of an exceptional and extreme demand. No health system is perfect and, although Australia's has some wonderful attributes that make it the envy of many other countries, it faces a number of important challenges. This paper describes how Australia's health care structure has adapted to respond to the COVID-19 crisis, examines the challenges involved and the lessons learned, and explores how this environmental pressure could lead to systemic adaptations.

## The Australian Health Care System

Australia has a 2-tier system, public and private. The public system, Medicare, is funded by the federal government and is available for Australian citizens and permanent residents. Two percent of taxable income with up to a 1.5% surcharge on high earners funds this component, which accounts for approximately 67% of total health care costs [1]. Australian health care in 2017–2018 cost \$170 billion, which is 9.6% of gross domestic product, slightly above the Organisation of Economic Co-operation and Development average [1]. However, the health cost to GDP ratio in Australia remains behind those of the United States, Canada, New Zealand, and the United Kingdom.

Public health care in Australia is subject to limited resources, leading to acute health care prioritization and waitlisting for non-urgent care. The general practitioner (GP) determines the medical treatment required, making referrals to public clinics before specialist care can be sought and treatment initiated. This all takes time and is only the beginning of the wait. If the referral is accepted, the patient is put on an outpatient wait list to see a specialist. Wait time is determined by acuity. If a problem is urgent, it will be attended to within 30 days of being added to the wait list, not from initial GP attendance. Semi-urgent conditions have a wait time of 90 days, and non-urgent problems wait up to 365 days. Patients with semi-urgent conditions wait 90 days, and those with non-urgent problems wait up to 365 days. These are targets: waits may be longer or shorter, depending on individual public hospitals. The patient

with an urgent bladder mass might not be assessed for 30 days, and the cataract keeping someone from reading or driving might not be removed for up to a year.

A parallel and optional private system puts patients in control, allowing them choice of treating physician, time to treatment, and location. Australian private insurance is market-based. Consumers purchase a policy with an assigned premium that suits their individual needs. This policy predominantly covers the cost of admission and health care provision in private hospitals. These facilities are completely separate from government built and run public hospitals. Private hospitals are owned and operated by independent companies, providing services partially Medicare funded and partially privately sourced, with insurance providing capped hospital excesses. Until very recently, public and private health care provision have, for the most part, remained separate.

## United Against a Common Enemy

The Australian health care system has evolved over many years to become the world-class service provider it is today. However, its strength in providing multifaceted tailored health care for a broad range of societal situations has led to bureaucratic rigidity. As the technological world exponentially expands, many Australian hospitals remain without even a universal electronic medical records system. The system is cluttered with several competing agendas and litigious fears to the detriment of efficient health care delivery.



However, on April 1, 2020, a joint media release stated the Australian Government would partner with the private hospital sector to help fight the COVID-19 pandemic [2]. Overnight, the entire structure of Australian health care provision was rearranged to aid the pandemic effort. Private hospitals were commissioned to service public category 1 elective surgeries and facilitate the transfer of public ward and ICU patients to private facilities. Not only did this secure an immediate 30 000 private hospital beds and 105 000 skilled workers but it also significantly increased the supply of in-demand consumables such as personal protective equipment (PPE), ensuring public hospitals were adequately buffered to weather the COVID-19 storm. Medical administration collaborated with clinicians and ground staff to put these measures swiftly into action with immediate results. It is as if the viral enemy at the door galvanised a sense of united toil to overcome the barriers of bureaucratic delay [3].

The pandemic has become a catalyst for health care development. A more flexible system, welding together public and private systems for optimal health care provision is merely the beginning of pandemic-initiated improvements. The advent of telehealth and

videoconferencing has increased access for rural and remote patients and facilitated multidisciplinary discussion and management. Working from home has seen creativity and innovation replace the pretence of productivity imposed by the “clock in, clock out” mentality. Efficient technological advances, ranging from safe aerosol-generating procedures to vaccination programs, have shown development can be rapid in the face of adversity. Unification of public and private sectors was symbolic of a broader unification of politician, clinician, allied health, and administration to implement effective and efficient health care.

## Conclusion

Australia's distinct 2-tier health care system has afforded inherent reserve to allow for immediate pandemic-proof reform. Unifying the systems to respond to a common adversary has enabled developments in health care provision that would not have been possible had they remained separate. If the Australian system is to remain adaptable and innovative, this unified model must survive beyond the pandemic.

## References

1. AIHW. Australian Institute of Health and Welfare: Australia's health 2018. Australia's health series no. 16: AUS 221; 2018.
2. Department of Health - Australian Government partnership with private health sector secures 30,000 hospital beds and 105,000 nurses and staff, to help fight COVID-19 pandemic 2020. April 1, 2020. Available from: <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/australian-government-partnership-with-private-health-sector-secures-30000-hospital-beds-and-105000-nurses-and-staff-to-help-fight-covid-19-pandemic>. Accessed September 16, 2020.
3. Khadra M. New normal post-COVID-19: Nepean's experience. *Med J Aust*. August 10, 2020.