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Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Private and public patients in public hospitals in Australia

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ARTICLE INFO

Article history:

Received 9 January 2013

Received in revised form

23 December 2013

Accepted 10 January 2014

Keywords:

Public hospitals

Private care

Equity

Australia

ABSTRACT

Introduction: The nature of the private–public mix in health insurance and in health care is a major issue in most health systems.

Objective: To compare the hospitalization characteristics of private and public patients hospitalized in public hospitals.

Methods: We focused on planned, overnight and same-day admissions, discharged during 2004–2005 from the public New South Wales hospitals, and run fixed-effects regressions in order to identify the effect of accommodation status (private/public) on the hospitalization characteristics.

Results: Private patients have one third less waiting days than public patients, and they are assigned higher urgency of admission. Length of stay and length of visit are both unrelated to the accommodation status, however, private patients tend to have more hours in ICU and more procedures performed during the hospitalization. In-hospital mortality and the number of transfers (wards) are not affected by the accommodation status.

Conclusions: Private patients are treated differently than public patients in public hospitals, reinforcing the private health insurance-related inequity in inpatient care identified by others. Two health policy issues emerge from the findings: the role of private health insurance in the Australian socialized medicine system, and in particular, in the public hospitals; and the way public hospitals are reimbursed for private patients.

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1. Introduction

The issue of the private–public mix in health insurance and in the delivery of health care has become one of the most intriguing issues in systems which are based on social health insurance or socialized healthcare system. In these systems, voluntary private health insurance (PHI) typically serves as a *supplementary* insurance, offering some “extras” to those who can afford it. What should be included in these “extras” is an open and controversial issue, since if these extras are not medically essential; an

efficiency-related fear of unnecessary coverage, waste and excess use emerges. If, on the other hand, essential care is included, an equity-related concern emerges.

The equity of the system – including equity of access and equity of outcomes – has been a major issue in the Australian health care system since the 1960s [1,7]. PHI has been a significant component of the Australian health system [2,3], and since 1997 the Australian government has encouraged its take-up, which reached 45% in 2010 [4]. In 2007, it financed about 8% of the national health spending. PHI covers, among other services, inpatient care in private hospitals and services delivered to private patients in public hospitals. In addition, it provides choice of doctors in public hospitals, and shorter waiting times. Thus, private and public patients may be admitted to public hospitals, even to the same ward, but possibly being treated differently.

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2. The private–public mix in the Australian health system

Introduced in 1984, the Australian Medicare system provides universal and affordable coverage for, among others, inpatient care in public hospitals (owned by the States/Territory).

Patients planning elective procedures may choose to be private or public patients. Public patients receive free inpatient care provided by doctors chosen by the hospital. Private patients (who are eligible for Medicare) in public hospitals are charged fees for inpatient care at lower rates than the full rates [4]. Copayment depends on the hospital's charges. Setting the charges, the hospital must take into account that if the charge is too high, the patients might decide to be treated as public patients, in which case the hospital will lose out any extra-budget revenue. Interestingly, accommodation charges in public hospitals are less than half the corresponding rates in private hospitals [4]. This gap may incentivize insurers to direct patients to public hospitals for the inpatient care they need.

This mix of private–public funds in the public inpatient system has raised concern. The quest for equity has been a major issue in the Australian healthcare system since the 1960s [1]. The most publicly debated issue remains waiting time for elective surgeries in public hospitals [5]. Waiting times in private hospitals are essentially zero.

Concerns over the inpatient public–private mix are intensified by the structure of the incentives existing in the system. While the care for public patients is financed through global budgets, and thus the hospital sees zero marginal revenue from treating public patients, the care provided to private patients is reimbursed as extra-budgetary income, and the hospital enjoys positive marginal revenue. Furthermore, doctors treating private patients are reimbursed by fee-for-service, and are incentivized to increase the volume of the treatment provided.

In this paper we use patient-level data to compare waiting time and admission urgency, use of hospitals' resources and outcomes between private and public patients hospitalized in NSW public hospitals, controlling for personal demographic, socio-economic and clinical characteristics.

3. The data, variables and statistical strategy

We used the merged, de-identified data from NSW Public Hospital Inpatient and Waiting Time data collections provided by the NSW Department of Health. We focused on planned (non-emergency), overnight and same-day admissions, discharged during 2004–2005 ($n=564,646$). The following cases were excluded from the analysis: patients who were not eligible for Medicare (such as overseas visitors, $n=15,046$); patients who were “not ready for care” (were not assigned urgency status, $n=45,384$); patients who were hospitalized (same day) on a regular basis (for e.g. Dialysis or Chemotherapy, $n=224,378$); patients whose care is paid for by workers compensation insurance, motor vehicle third party insurance, veterans affairs, or the defence forces ($n=10,500$), and patients with missing wait time data ($n=7020$). The working sample

consists of 93,064 overnight and 151,304 same-day separations. 14.5% and 12.6%, respectively, were “private”.

We classified the hospitalizations' characteristics (dependent variables) into three components: Waiting time and admission urgency; use of hospitals' resources (length of stay/length of visit, hours in ICU, and the number of procedures performed) and outcomes (in hospital mortality, number of wards/in hospital transfers). We included the number of in-hospital transfers as an outcome variable, since, for a given length of stay, ICU time and the number of procedures, transfers among wards usually occur as a result of complications such as infections. The empirical definitions of these variables and their means for private and public populations are presented in Table 1A for overnight separations and in Table 1B – for same-day separations.

Patients' characteristics included demographics – age, sex, marital status and country of birth; socio-economic indicators – Aboriginal and Torres Strait Islander origin (ATSI), indicator and the Socio-Economic Indexes For Areas (SEIFA) score which is based on the socio-economic characteristics of citizens in postal areas, where higher score indicates higher socio-economic status (for more information see <http://www.abs.gov.au/AUSSTATS/latestproducts/2039>); and clinical information – the number of diagnoses, hospital identity and the Indicator Procedure Code (IPC), which classify patients on the waiting list according to the main anticipated treatment (e.g. cataract extraction, total hip replacement or coronary artery bypass graft). We note that the IPC is different from the “number of procedures performed” mentioned earlier: the IPC specifies the main general reason for the hospitalization and is predetermined in admission. The number of procedures counts the specific procedures and treatments performed within the general IPC, and is determined during the hospitalization. Unfortunately, the clinical information is incomplete in reflecting the severity of the illness. However, the IPC combined with the number of diagnoses reflect the essential severity information registered in the inpatients' records.

The regressions which were run for the dependent variables differ according to the nature of the dependent variable. OLS regressions were used for (the natural logarithm, denoted by log, of) waiting time, (log) length of stay (LOS), (log) ICU hours, and (log) length of visit (LOV). Poisson regressions were used for the number of procedures performed and the number of transfers. An ordered Logit regression was used for assigned admission urgency, and a Logit model was used for in-hospital mortality. All the regressions were estimated with fixed effects for IPCs and hospitals (not shown).

4. Private and public patients

From Tables 1A and 1B we can generally conclude that the public patients – relative to the private ones – are older; include more men, unmarried persons and ATSI; have lower SEIFA scores; and are less likely to have been born in Australia. Private patients have a lower number of diagnoses in overnight but a higher number in same-day hospitalizations. However, when all other individual

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