

## Private care and public waiting

**TO THE EDITORS:** Having had oversight of the surgical waiting list at a large Melbourne teaching hospital over periods from the mid 1980s to the late 1990s, I read Professor Duckett's paper with some interest. He correlates the proportion of activity in public hospitals and patient waiting times; and suggests that surgeons were responding to "a perverse incentive to maintain high waiting times in the public sector to encourage prospective patients to seek private care" (page 88).<sup>1</sup> It is unlikely the suggested causal relation exists and that surgeons as a group are behaving in this fashion.

There is a more likely alternative explanation. The major factor limiting elective surgery while I worked in the public sector was lack of money, not lack of surgeons willing to work in the public sector. Elective surgery virtually ceased for 8 weeks about the time of major holidays. Elective surgery was further reduced by the frequent cancellation of cases because emergency cases reduced overnight bed availability. If sufficient funds had been available, the holiday closures would have been reduced and more beds opened.

The hospital I worked at was over budget and exceeded its output (Weighted Inlier Equivalent Separation [WIES]) target. This was the reason it was unable to undertake additional surgical activity. Surgeons frequently complained about restriction on theatre time and cancellation of elective cases. These problems were common across large Melbourne hospitals.

The 2001–02 Annual Report of the Victorian Department of Human Services (DHS) suggests nothing had changed by that time. Hospitals exceeded their WIES target and were over budget.<sup>2</sup> If hospitals had undertaken more elective activity their deficits would have been higher.

Box 1 (which outlines median waiting times and proportion of public separations by indicator procedure) also requires further consideration. No distinction has been made between the various procedures with respect to the likely

differences in urgency category and whether cases are generally ready for immediate care. For example, coronary artery bypass surgery cases are generally category 1 urgency and are expected to be treated within 30 days, but septoplasty cases are generally Category 3 urgency without a major time imperative. The waiting times for these two procedures are not comparable. Cystoscopies are often undertaken at regular intervals and frequently put on the waiting list well before the surgeon wishes to perform the procedure. They are not ready for care until near the procedure date, and their waiting time is not comparable to procedures where most cases are immediately ready for care.

If Box 1 contained only procedures that are generally ready for immediate care and category 2 urgency (should be treated within 90 days) a potentially confounding variable would have been removed. Victorian hospitals face financial penalties if category 1 cases wait over 30 days or if more than a small proportion of category 2 cases wait over 90 days. This is reflected in the results in Box 1.

If public sector funding increased it is highly probable more elective surgical cases would be performed and waiting times reduced irrespective of private health insurance uptake. The quantum of funding is the most important factor affecting waiting time.

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1 Duckett SJ. Private care and public waiting. *Aust Health Rev* 2005; 29(1): 88. Available at: <[http://www.aushealthreview.com.au/publications/articles/issues/ahr\\_29\\_1\\_0205/ahr\\_29\\_1\\_087-093.asp](http://www.aushealthreview.com.au/publications/articles/issues/ahr_29_1_0205/ahr_29_1_087-093.asp)> (accessed Jun 2005).

2 Victorian Department of Human Services. Annual Report 2001–02. Melbourne: VDHS, 2002: 28. Available at: <[www.dhs.vic.gov.au/annrep/ar0102](http://www.dhs.vic.gov.au/annrep/ar0102)> (accessed Mar 2005).

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**IN REPLY:** Dr Hanning has made some interesting points in his letter. It is important to stress, though, that the quote in his first paragraph is from the literature review section of the article and is not a conclusion that I have drawn in the paper. His “alternative explanation” is that budget constraints in the public sector reduce the time available for elective surgery, and in turn contribute to longer waiting times. That is not an alternative, as both factors could be at play and funding constraints indeed could contribute to increased waiting times, as could surgeons’ behaviour. Consideration of funding constraint as a cause leads to the suggestion that there should be additional funding for the public sector and

the private health insurance rebate could be a possible funding source.

Dr Hanning also draws attention to some of the limitations of methods in the paper. The analysis that could be undertaken in the article was constrained by the available data. I used nationally available data from the Australian Institute of Health and Welfare, and unfortunately this does not allow for the refinements that Dr Hanning suggests.

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