PUBLIC AND PRIVATE UTILISATION OF IN-PATIENT BEDS IN IRISH ACUTE PUBLIC HOSPITALS

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Health care systems in many developed countries have services financed and provided by both public and private sectors. In Ireland, though, the public/private mix is atypical: a private patient can be treated in an acute public hospital and seen by a consultant who may also treat public patients within the same hospital. Nationally, one in five beds in acute public hospitals is designated for use by private patients and existing legislation restricts accommodation of a private patient in a public-designated bed. Yet there are concerns that acute public hospitals may sidestep such restrictions on their private practice, resulting in public hospital resources potentially being diverted away from public patients towards their private counterparts. Indeed, Irish providers face financial incentives which favour the treatment of private patients. Consultants are rewarded on a fee-for-service basis for private care, but receive a salary for public practice. Public hospitals, meanwhile, receive a fixed daily payment for every private patient in a private bed. Added to these financial incentives is an increased opportunity to engage in private practice due to the substantial recent growth in private health insurance subscribers.

Our paper† uses data on the public/private status of discharges to examine the utilisation of designated private and public in-patient beds in Irish acute public hospitals over the period 2000-2004. In each year, estimated actual utilisation of beds by private and public in-patients at hospital level was compared with the bed capacity potentially available for each group. The annual number of bed days used, obtained from the Hospital In-Patient Enquiry scheme, measured actual utilisation. Potential utilisation was estimated using data on the number and designation of in-patient beds obtained from the Department of Health and Children.

The results of our analysis indicated that private in-patients used more bed days than were theoretically available to them in 14.1 per cent of hospital-year observations. The equivalent figure for public in-patients was 12.6 per cent. Although the prevalence of excess utilisation of private in-

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patient beds was relatively small and nearly balanced out across the public hospital system as a whole, it did increase over the study period.

It would appear, therefore, that some acute public hospitals have apparently been able to overcome restrictions imposed on them in relation to the volume of private practice. Our results are consistent with at least two competing hypotheses. Firstly, excess private utilisation may be compatible with the efficient use of scarce resources by hospitals where demand from public patients is low (and vice-versa where there is excess utilisation by public patients). Alternatively, given fixed capacity constraints in the short run, excess private utilisation could imply a re-distribution of resources from public to private in-patients and could be consistent with allegations of public patients being displaced by their private counterparts. Further research is required to determine which hypothesis is correct given this Irish experience, and thus ascertain the appropriate policy response. From an international perspective, our findings illustrate how differential payment mechanisms in a mixed public/private system may influence provider behaviour, potentially resulting in the preferential treatment of one patient group to the detriment of another.

† O'REILLY, J. and M. WILEY, 2010. Who's that sleeping in my bed? Potential and actual utilization of public and private in-patient beds in Irish acute public hospitals. *Journal of Health Services Research & Policy*, Vol. 15, No. 4, pp. 210-214.