Response: public and private intervention rates in obstetric practice

To The Editors: Dodd and Robinson (2004) present a commentary on our recently published work (Shorten B & Shorten A 2004) which examines the trends in obstetric interventions within New South Wales (NSW) public and private hospitals from 1997–2001. We welcome discussion on this important issue which has both clinical and economic implications. They acknowledge that our emphasis on recent changes in subsidies for private health insurance adds a concerning new dimension to what is a well established debate regarding obstetric intervention rates in Australian private and public hospitals. Rather than being primarily a concern for the ‘health funders’, it has implications for all Australian taxpayers, who bear the opportunity costs associated with subsidising potentially ineffective, or even harmful, health care interventions or models of care at the expense of other worthy health care programs.

In acknowledging that risks and benefits exist for all health care choices we must be cautious in recommending that as long as consumers are fully informed of the risks and benefits then it is acceptable to provide funding, ignoring the broader societal implications of such resource consumption. Therefore the need for “transparency and accountability” (Dodd & Robinson 2004, p. 11) within the private obstetric sector is both an economic and ethical imperative.

One of the interesting contradictions in contemporary obstetrics is the use of the argument that consumer demand is a contributing factor behind the growing rate of birth intervention. However, practitioners simultaneously recommend funding of high quality research with the purpose of gaining better evidence upon which to base clinical practice. It is important for high quality evidence to be produced and disseminated, but the existence of that evidence alone will not address the current trend in obstetric interventions. Those who support the principles of evidence based practice will be aware of the challenges faced by those attempting to ‘get evidence into practice’. The presence of evidence does not equate to evidence-based practice, and consumers are not necessarily aware of this. Further, the presumption that consumers are not well informed about the vitally important consequences of their health care choices is a central pillar underpinning extensive public regulation of, in particular, the health care professions. This provides further reason to be cautious in evaluating arguments relating to consumer choice as a factor in observed interventions and outcomes.

If it is the case that “most private obstetricians are also gynaecologists, and work in several settings; and . . . non-clinical factors may have a greater impact on interventions than evidence from systematic reviews” (Dodd & Robinson 2004, p. 11), then the priority lies not in simply producing more evidence but in developing and implementing strategies to ensure use of best clinical practice. Public policy regarding birthing practices should not be influenced by the business imperatives of clinicians and/or hospitals. Accountability and transparency are indeed required to ensure that the private hospital industry is providing optimal and cost-effective services and outcomes from a societal perspective. A broader implementation and evaluation of various midwifery models of care within the private sector could contribute to achieving this aim.

Dodd and Robinson (2004) argue that there is a lack of evidence for any particular rate of intervention for birth, and therefore that well-informed consumers and practitioners must make individual choices about such interventions. While this may be argued at the level of the individual, it cannot be extrapolated to suggest that if consumers are well informed widely different population rates of procedures such as caesarean section, induction of labour, epidural block and instrumental birth in NSW private hospitals are equally efficacious as those in NSW public hospitals. We are, after all, analysing women in the same state of the same country for the same period of time, and socioeconomic and measured clinical factors suggest that the group least at risk
of adverse outcomes (the privately insured) is experiencing much higher rates of birth interventions. Either privately insured women are experiencing many unnecessary interventions, partly at the expense of the Australian taxpaying population, or publicly insured women are being denied access to best practice care through inadequate levels of intervention. Health care services cannot have it both ways. Furthermore, in both public and private settings, we have documented a pronounced upward trend in most interventions. It is surely quite proper to question whether these trends are positive or negative — they are certainly cost-enhancing.

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**Why it is time to review the role of private health insurance in Australia**

**TO THE EDITOR:** Since its introduction on 1 January 1999, the 30% rebate has been the subject of much misleading comment by the opponents of the private health sector. A recent addition to these ranks was published in the first edition for 2004 of *Australian Health Review* (Segal 2004).

There is no real attempt at balance in the article. While Segal argues that the rebate has failed to take the pressure off public hospitals, we are not told, for example, that almost one-in-five extra patients admitted by public hospitals in the three years to 2002-03 were actually private patients!

Similarly, the article is littered with generalisations and, in some cases, misleading or completely incorrect statements, such as “Private hospitals do not offer a complete hospital service . . .” Even a cursory examination of the available national data indicates that private hospitals provide services in all but 7 of the 654 diagnosis-related groups (DRGs) recorded. Private hospitals perform all the remaining 647 DRGs.

In 200 of these DRGs, private hospitals treat more than 38% of all patients, even though private hospitals account for only 34% of all hospital beds. For example, in 2002–03, private hospitals provided 42% of all coronary bypass operations, 46% of all cardiac valve procedures, 54% of major procedures for malignant breast conditions, 55% of hip replacements, and 71% of major wrist, hand and thumb procedures. All this from a sector that, according to Segal, “ . . . can choose to focus on the more profitable health services.”

Segal tells us that “ . . . the private hospital system focuses on elective surgery, and within that, the more profitable area of day surgery.” Again, a look at the independent national data from the Australian Institute of Health and Welfare actually shows a different picture. In 1998–99, private hospitals provided 28.3% of total overnight separations and 37.4% of same day separations. In 2002–03, the private hospitals sector provided 32% of total overnight separations and 44.0% of same day separations. Since 1999–00, overnight admissions to public hospitals have fallen by 15 000. Over the same period, overnight admissions to private hospitals increased by 97 000!

Finally, we have the good old standby of “ . . . most of the oldest, poorest and sickest patients will be cared for publicly . . .” Again, the data shows that this is simply untrue. For example, in 2002–