

The Average Length Of Stay (LOS) In The Hospitals Of The United States

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In general, the average length of stay (LOS) in short-term, non-federal hospitals has been decreasing in the United States. As hospital operation statistics became accessible to the chief administrator of the medical program, one factor that perplexed those in charge of the program was the large variations found in the average length of stay in the four American census regions. The Medicare payees who are hospitalized in the Northeast region usually stay for a few days longer than patients with related diagnoses in the West. Similarly, there is also a consistent variation in the hospitalization rate, although not as large as the variations found in the length of stay.

The number of hospital stays for every 1000 people enrolled in Medicare was greater year after year in the North Central and South, as compared to the Northeast and West regions. In 2012, the rate of hospital stays was lower in the Mountain and Pacific divisions. Patients admitted in the Northeast recorded a longer length of stay, while those in the West had the highest average hospital costs. The West had a subsequently lower rate of hospitalization (97.2 stays per 1000 people) compared to other areas (120 to 125 stays per 1000 people). On the other hand, the Northeast recorded the longest average stay of 4.9 days, while the West had the shortest average length of stay of 4.3 days.

The average hospital length of stay, especially in America, differs depending on region. One factor that causes variations in the length of stay is the financial problems of the healthcare institutions. In some parts, especially the West, this issue has led to prolonged hospital stays. Consequently, research has proved that the length of stay may either be long or short, depending on the increased risk and issues of readmission. Whenever a patient is readmitted, the stay is lengthened, and this becomes a challenge to the health facility both regarding time management and financial resources. Also, as much the doctors are responsible for treating the patients, they are also capable of influencing the patient's length of stay.

It is accepted that the medical condition of the patient is a chief determinant of the length of stay. Fourteen DRGs were found useful in determining up to 30% of the variations in the mean log length of stay. Therefore, those DRGs with the major sentimental disorder were linked with the main fraction of explained variation because they had the greatest mean length of stay. The main reason why DRG patients stay longer in hospitals is that there is no objective regularity to assess the outcome of treatment. (Weiss & Elixhauser, 2014) Hence, DRGs are usually formed by the homogeneity of diseases, which may be evaluated using the indicator of the length of stay. This implies that variations in the length of stay influence DRGs.

Also, other factors that may be responsible for explaining the length of stay are worth considering. According to research, it has been proved that worker's compensation assurance (WCA) and publicly

funded patients stay longer in hospitals than private patients. These findings are in line with the study, which shows that the payment status of the patient can make him/her more involved in the decisions, which in turn affects the length of stay. Correspondingly, ethnic groups are recorded as Aboriginal and Non-Aboriginal. The Aboriginal patients stayed longer than the non-Aboriginal patients. Lastly, referrals from outpatient departments and a hospital waiting list may predict variations in length of stay. The possible reason for this is that the unpredictability in outpatients and a waiting list is less than post-admission and interhospital transfer change; this, therefore, implies that the patients who are admitted as post-admission or interhospital transfers have a longer length of stay.

Shifting our argument towards the health policies in America, it is clear that healthcare payment has completely addressed the issue of extended hospital stays. For instance, in hospitals, before any form of treatment is done, the patient is assessed first, and their financial credibility is assessed to determine the considerations to be made. Lately, most healthcare systems have embarked on more ground-breaking changes to meet modern health policies, which are to improve outcomes, improve quality, and improve coordination. As a result, three distinct payment trends might be observed they include:

Add-On Payment

These are payments made on top of existing payment methods, mostly for improving the coordination of activities or pay for performance. It is, therefore, focused on improving the quality of care.

Bundle Payment

These payments are made to cater to chronic conditions, and they are often relevant for a specific treatment or medical condition, where they are grouped for payment. The main aim of this process is to reduce the cost of medical care and improve the quality of care.

Population-Based Payment

Here, groups of health providers receive payment depending on the population covered, so that they may provide efficient health care services for the target population, with cost—containment, and built-in quality.

Finally, health policies encourage patients to use health cards that come with fitness insurance programs. This card assists the holder in receiving cashless medical assistance at any network hospital. Also, the card contains numbers that assist the patients in case they have any pressing concerns. Moreover, the health payment policy has also led to reimbursement; what this implies is that after the patient presents themselves for treatment, they can easily make cash payments for all the hospitalization expenses. (OECD, 2023) If need be, the patient may claim compensation for all the

expenses incurred by presenting all the necessary documents.

Asthma is the main public health problem nationally and in the State of New York. Data from the Federal Center for Disease Control and Prevention (CDC) has proved there has been a steady increase in the occurrence of protracted lung diseases throughout America recently. However, in New York State, the overall deaths from asthma and asthma-related hospitalization have reduced. The public health and financial consequences of asthma remain significant. As of 2012, an estimated 1.4 million adults in New York suffer from asthma. In 2010, 315,000 children were reported to have asthma. According to health experts, the standardized asthma admission rate in the United States varies between nine to twelve million for individuals of all ages yearly. It is evident that asthma mortality and hospitalization rates have risen ever since 1979. From 1965 to 1982, the hospitalization of asthma patients was above average, with the black community being more affected than the white. The asthma death rates in the nineties increased by about 30%, and the deaths were higher among old people. Considering the state geographic analysis, it is factual to say that asthma morbidity and mortality are not uniformly distributed across America.

In conclusion, variations in hospital length of stay in the United States may be resolved through strategic and proper planning to ensure that all health policies are implemented. These policies are beneficial since they assist low-income families in paying their large medical expenses. As a final point, every citizen has the right to and is entitled to convenient, high-quality, and free medical care.

References

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