Day Care Surgery: The United States Model of Health Care

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Abstract

In the USA, "Ambulatory Surgery" means that the patient goes home at the end of the working day. Facilities for surgery in the USA are primarily owned by the private sector, and are provided in hospital outpatient departments (HOP), freestanding ambulatory surgery centers (ASC), and office-based surgeries. Most citizens in the US get their health insurance from private for-profit plans from their employer, and in addition a government program for citizens 65 years and older (Medicare). HOPs and ASCs are paid under a prospective payment system called ambulatory payment classifications (APCs). APC payments are primarily based on actual reported costs, minus a percentage to encourage efficiency, and the amount paid to ASCs is based on a fixed fraction of HOP costs. Office based ambulatory surgery is paid under the physician reimbursement system. Ambulatory surgery in the US is successful because we have developed and utilize different evaluation, education and perioperative processes for care of these patients, and because there are no governmental payment obstacles.

Keywords: ambulatory surgery, health care system, payment systems.

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Day Care Surgery: The United States Ambulatory Health Care

Definitions

In the USA: "Ambulatory Surgery" means that the patient goes home at the end of the working day. There is no overnight stay. In the USA there is no extra payment for overnight stay, and there is no system of patient "recovery hotels".

We can look for a non-USA definition from the International Association for Ambulatory Surgery (IAAS), which defines ambulatory surgical care to cover a similar group of circumstances. In the "IAAS Recommendations for the Development of Ambulatory Surgery Programmes"*, Tom Ogg wrote: " A surgical day case is a patient who is admitted for investigation or operation on a planned non-resident basis and who none the less requires facilities for recovery. The whole procedure should not require an overnight stay in a hospital bed."

Facilities for Surgery in the USA

Facilities for surgery in the USA are primarily owned by the private sector and not by the government. Most hospitals treat a mix of both private and public patients. By law hospitals must provide urgent care for everyone, independent of any payment. The public hospitals, often managed by large city governments, do a similar percentage of ambulatory surgery as private-sector hospitals.

Ambulatory surgery is provided in three different categories of facilities: Hospital Outpatient departments (HOP), freestanding ambulatory surgery centers (ASC), and office-based surgeries (OBS).

In 1981, it was estimated that 80% of surgery in the US was done on inpatients and 20% was done on outpatients. By 2001, those percentages had essentially reversed, with an estimated 24% inpatient and 76% outpatient. The percentage of ambulatory is still continuing to grow, to an estimated 83% in 2006, or approximately 41.6 million ambulatory surgery procedures a year. The location of these operations has also changed over time. In the first decade after 1981, the growth was in HOP, form 18%to $44% of all surgery, and this percentage has remained essentially stable. My unit at the Brigham and Women's Hospital was opened in 1980. In the next decade, the growth was in ASCs, from 10 % to 17%. Subsequently the growth has primarily been in the OBS sector, from 14% to 20% in the following decade, and growth continues in that sector. (SMG Marketing Group, Chicago) We are seeing the continuing shift of more complex operations and procedures from the inpatient hospital to the outpatient settings in all the various forms.

Health Insurance for Patients

Most citizens in the US get their health insurance primarily from private for-profit plans from their employer. Most private plans require some patient co-payment and paid facilities negotiate amounts and have some restrictions on benefits in order to limit expenditures.

In addition, the US federal (national) government provides healthcare for some citizens. The major government payer is the program for citizens 65 years and older, called Medicare. There are additional government-supported programs including one for the poor and disabled (called Medicaid), for veterans and for active military.

Healthcare Facility Payment

U.S. healthcare facilities are paid by private and government payers. The largest payer is Medicare, from the federal government. It pays inpatient hospital care under a prospective payment cost-based system, using diagnosis related groups (DRGs), a payment that includes preoperative and postoperative care. Physicians and other individual providers are paid separately also with a combination of private and government sources.

Hospital-based ambulatory care overall is paid under a different prospective payment system. Here, surgical and medical care is grouped into ambulatory payment classifications (APCs) by clinical similarity and similar resource use. Payment under the APC system is primarily based on actual reported costs. Each APC has a relative

weight, based on median costs and made budget neutral with a weight scaler. An annual conversion factor is calculated based on wage index and market basket with a rural adjustment. Payment is then calculated by multiplying the scaled weight by the conversion factor. The budget neutrality of the APC system means that if payment to some APCs increase, others will decrease. Finally, calculated payment under the APC system is reduced by a percentage to encourage efficiency. Initially the payment was 82% of actual costs but the exact amount varies from year to year.

Payment for ambulatory surgery in freestanding ASCs is part of the same APC system. The amount paid to ASCs is based on a fixed fraction of hospital-based ambulatory costs, which is currently at 65%. This payment differential exists because freestanding facilities do not provide full coverage nights or weekends, have emergency rooms, or provide free care. Office based ambulatory surgery is paid under the physician reimbursement system. The physician is given a "site of service payment" in addition to his professional fee.

Why is Ambulatory Surgery in the USA So Successful?

Ambulatory surgery in the US is successful because we have developed and utilize a different process for care of these patients. The ambulatory surgery process consists of a patient evaluation process, a patient education process and a perioperative care process, all different from the inpatient pathways. In addition, there are separate systems to promote and assess quality of care for ambulatory surgery patients. Ambulatory surgery processes in the US have two primary focuses. One is a focus on efficiency, quality, and cost of care. The second is a focus on patient and humanism in medicine.

The second major reason for the success of ambulatory surgery in the US is the lack of payment obstacles. The success of ambulatory surgery worldwide is not dependent on patient acceptance. Patients prefer to be back to normal, to feel healthier sooner rather than later. The major determinant of ambulatory surgery growth worldwide is, instead, governmental. The difference is in the method of funding health services. In the US the government only needed to make the economic incentives equal to make ambulatory surgery an outstanding success. In the 1980s, when surgeons were newly paid the same whether they provided care on an inpatient basis or an outpatient basis, and when hospitals were paid the same for patient stays of two hours or two days, this removed the obstacles and ambulatory surgery in the US grew dramatically.