ELSEVIER

Ambulatory Surgery 9 (2002) 179–185

Ambulatory Surgery

www.elsevier.com/locate/ambsur

Australian (Commonwealth) government policy on day surgery (Ambulatory Surgery) with particular emphasis on the private sector

P. Callanan *

Private Health Industry Branch, Australian (Commonwealth) Department of Health and Aged Care, P.O. Box 9848, Canberra, ACT 2601, Australia

Received 1 August 2001; accepted 8 November 2001

Abstract

This paper examines the growth in day surgery in Australia utilising available data for the period 1991–1992 to 1998–1999. An outline of the Australian health care system is given to provide the relevant background to the day surgery environment. The growth in day surgery will then be examined with a discussion of how this growth has lead to the need to reform, and the intended direction of this reform.

Keywords: Medicare; MBS; Private acute care

1. Introduction

1.1. The Australian health care system

The Australian health care system has a number of unique features. Medicare, a system of universal health cover for all Australians since 1984, provides health care funding to the tune of $A6 billion dollars per annum. This scheme is supported by others such as the Pharmaceutical Benefits Scheme (entailing funding of $A3.8 billion per annum in the 2000–2001 financial year).

Consumers support Medicare indirectly through general taxation. Although a Medicare Levy of 1.25% is paid through taxation, this does not fund Medicare directly, but again, is paid into general revenue. High-income earners must pay an extra 1% levy if they do not have private health insurance hospital cover. Medicare supports primary and acute medical and surgical care. Primary health care visits to general practitioners or specialists are subsidised by the Commonwealth and the level of subsidy is determined in the Medicare Benefits Schedule (MBS). The MBS includes a range of medical, surgical, consultation and diagnostic procedures where the government sets the procedural fee payable by the Commonwealth. Notwithstanding this, medical practitioners can charge fees higher than the fee determined in the MBS.

Acute care has two distinctive aspects. Public acute sector health care is delivered and managed by the states and territories in Australia with joint funding and formal agreement with the Commonwealth, known as the Australian Health Care Agreements. Patients who elect to receive public acute care as admitted or non-admitted patients are not billed for any aspect of this care.

Private acute care is primarily delivered through private hospitals and day hospital facilities. Funding for this care is primarily through health insurance funds on behalf of their members who pay contributions to such funds. A minority of patient's fund their own private health care (self-funded). Medicare provides some financial subsidisation for all private patients in a private acute care setting.

Private health insurance is regulated in Australia and, as such, there are restrictions upon the levels and types of benefits that can be paid by health insurance funds on behalf of their members (the patients).

* Fax: +61-26289-9888.

0966-6532/02/$ - see front matter
PII: S0966-6532(01)00129-9

1.2. Private hospital insurance cover

At September 1997 [1], 32% of the Australian population held private health insurance compared with 45.4% of Australians at 31 December 2000, an increase of 13.4% over the 3 year period. Hospital cover only relates to services provided to admitted patients on either a same day or overnight basis.

Major initiatives contributing to the increase in private health insurance for the 1999–2000 financial year were the implementation of two major Australian (Commonwealth) Government (the Government) initiatives. The first, the 30% rebate has contributed to increased numbers of Australians joining and retaining their private health insurance. This rebate has immediately improved the affordability of health insurance for members of health funds. The rebate reduces the cost of health insurance premiums by 30%, regardless of an individual's income, family structure or level of cover.

The second major initiative, Lifetime Health Cover, recognises that because health care costs increase with age, those who join at younger ages should pay less than those who join at a later age, which has the effect of encouraging younger people to join. Where this increase in younger members also brings an increase in healthier members, the risk profile of members is improved overall. This has the effect of reducing the frequency and size of premium increases, which might otherwise be needed to cover the level of fund expenditure for older, less healthy members.

1.3. Private ancillary insurance cover

As at 31 December 2000 [2], 40.4% of Australians held ancillary cover, compared with 31.8% at 30 September 1997, an increase of 8.6% over the 3 year period. This is a qualified increase, given that a contributor may choose to hold hospital insurance with one health fund and hold ancillary cover with another. Ancillary services, provided by such cover, include services such as dental, occupational therapy, physiotherapy, speech therapy etc, not covered by Medicare.

1.4. Private health insurance in Australia

From a health insurance and Australian Health Care Agreements perspective, although day surgery has only recently been recognised as a legitimate procedure, it has been around since the early 1980s. Whilst the broad concept of day surgery is self-evident, broader government objectives for the role of private health insurance have directly encouraged an increasing trend towards more sophisticated surgical procedures to be undertaken on a same day basis in both the public and private sectors, without relinquishing quality, safety and other imperative issues related to patient care and outcomes.

These Government objectives focus on maximising the effectiveness of the health system in delivering improved health for the Australian community; caring for those with chronic poor health; ensuring equity in the delivery and financing of health services; and improving the efficiency of individual health service providers as well as the industry as a whole [3].

Private health insurance also recognises the essential role of the private sector, and seeks to capitalise on the strengths of both the public and private systems in building a better health system within Australia. Private health insurance is sometimes portrayed as competing with Medicare, and sometimes as complementing Medicare. In a sense, it plays both roles because those with private health insurance are still eligible to receive care that is free at point of delivery within the public sector [4].

The Government is committed to maintaining a successful balance between public and private health care. This means retaining Medicare in its entirety, working towards a strong and viable private health system, and ensuring private insurance is a realistic option for all Australians.

Furthermore, private health insurance in Australia is based upon the principle of 'community rating' and not 'risk rating'. This principle seeks to equalise premiums for high and low risk contributors in order to meet the broad equity objectives of government, such as access to private health insurance membership or benefits.

1.5. Day only facility benefits and banding

In Australia, the minimum levels of day facility benefits payable by health funds are set by the Commonwealth, in consultation with the states and territories. Such levels are known as the Default Table of Benefits. The minimum benefit levels for same day treatment are based upon the level of anaesthesia and theatre time, using four banding classifications and a non-band specific classification.

- Band 1 is a definitive list of procedures with no flexibility for reclassification to another band.
- Band 2–4 are determined by anaesthetic type and theatre time.
- Non-band specific Type B list can be banded according to anaesthetic type and theatre time. In the absence of anaesthetic and theatre, a Band 1 classification is applicable.

This banding system has been in place for over 10 years and, like most things, needs to be reviewed in order to ensure it reflects the current day surgery environment and that it is acceptable to medical practitioners, hospital systems (public and private), health insurers and the consumer or patient.

The Default Table of Benefits identifies three types of categories of professional attention (i.e. attendance/treatment by a medical practitioner), namely:

Type A: professional attention normally requiring admitted overnight hospital stays.
Type B: professional attention normally requiring admitted hospital treatment, but does not include part of an overnight stay.
Type C: professional attention that normally does not require admitted hospital treatment.

Movement between these bands, i.e. from a Type B to Type A, requires certification by a medical practitioner to enable higher benefits to be paid to the hospital or day hospital facility by health insurance funds.

Overnight accommodation benefits are not payable for Type C professional attention unless overnight certification, in addition to day certification, is provided. In order for an overnight benefit to be payable to a patient in receipt of a Type C procedure requiring hospitalisation, the practitioner providing the professional attention must certify in writing that:

(a) because of the medical condition of the patient specified in the certificate, or;
(b) because of the special circumstances specified in the certificate.

It would be contrary to accepted medical practice to provide the professional attention to the patient unless the patient were given hospital treatment in the hospital for a period that included part of an overnight stay.

2. Advent and growth of the day hospital facility

In earlier decades in Australia, acute care whether publicly or privately funded, has required overnight stay(s) in hospital. Advances in surgery-related technology, anaesthesia and post-operative care has enabled certain procedures to be undertaken on a day only admission basis.

Prior to 1984, private health insurance benefits in Australia were not generally paid for acute procedures that did not involve an overnight stay in hospital and, if they were, it was on an ad hoc basis. Legislative and regulatory changes since then have provided a formal structural basis for private health insurance benefits to be payable for procedures undertaken on a day only admission basis.

This has eventually lead to the distinction between services provided on a day only basis. All overnight hospital facilities are able to undertake procedures on a day only basis as a service provided by the existing hospital or as a separate or integrated unit within the existing hospital structure. Patients undergoing these procedures are typically known in Australia as same day (admitted) patients.

With the allowance of private health benefits to be paid for day only procedures, there was also the development of a new type of acute facility, the free-standing day hospital facility. Free-standing day hospital facilities have become a growth area in acute care that, as outlined below, represent a small but significant provider of day only procedures in the total hospital services in Australia.

3. Results and discussion

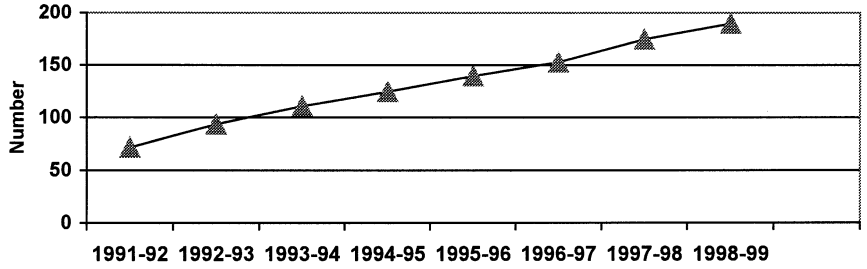
3.1. Facility and bed numbers

For the past decade, free-standing day facilities have grown not only in number, but also in the range of services available.

Table 1 shows that the number of free-standing day hospital facilities has more than doubled from 72 in 1991–1992 to 175 in 1997–1998. Data to 1 April 2001 shows around 209 free-standing day facilities exist, including five free-standing day facilities this financial year [5].

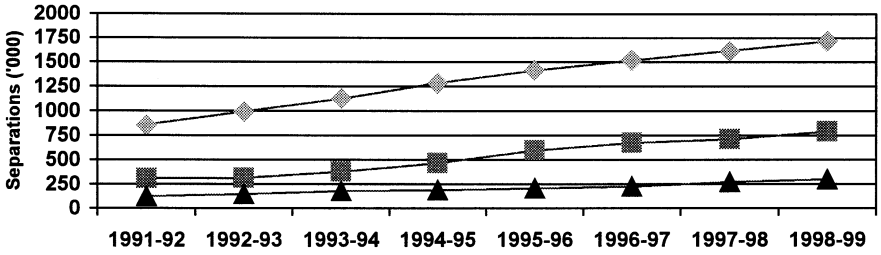
The growth in free-standing day facilities has by far outnumbered any change in private acute hospitals over the same period. Private acute hospital numbers have slightly decreased with 319 facilities in 1991–1992 and 312 in 1998–1999. The number of public overnight facilities, has remained virtually static. There are ap-

Table 1
Growth in freestanding day facilities



Source, Australian Bureau of Statistics Private Hospitals 1991–1992 to 1998–1999.

Table 2
Same day separations (publicly and privately funded and free-standing day facilities)



—◆—, public day separations; —■—, private day separations; —▲—, day hospital facility separations; Source, Australian Bureau of Statistics Private Hospitals 1991–1992 to 1998–1999 and Australian Institute of Health and Welfare Australian Hospital Statistics 1997–1998, Table 4.1.

proximately 784 public hospitals ranging in size from ten-bed hospitals to 997-bed hospitals (the largest hospital being Royal Brisbane Hospital, Queensland).

The strong growth in the number of private free-standing day hospital facilities, which has been evident over the last few years, continued during 1998–1999. Between 1997–1998 and 1998–1999, the number of facilities increased from 175 to 190 [6].

Free-standing day hospital facilities may provide general surgery, endoscopy, ophthalmic and other specialities (fertility management, plastic surgery and sleep disorders). The main distinguishing feature between a day hospital facility and a traditional hospital is that day hospital facilities do not generally provide overnight accommodation for patients. Growth of free-standing day hospital facilities has varied greatly between the states and territories because of varying state and territory legislation, set against a background of Government initiatives which have encouraged the provision of increased admitted day only stays in lieu of the traditional overnight stay.

The growth in free-standing day hospital facility numbers and status in overnight facility numbers corresponds with growth in the number of available beds. Whilst growth in free standing day facility bed numbers may appear large such bed numbers account for only 6% of available private overnight beds (1998–1999) and less than 2% of all hospital beds in Australia.

As may be observed in the discussion below, the number of available beds in Australia (public, private and free-standing) means there is the capacity for a large expansion in the volume of same day procedures as a viable substitute for overnight acute care.

3.2. Patient separations and patient days

The growth in privately owned and operated free-standing day facilities has also seen a corresponding increase in patient separations from these facilities (123 400 separations in 1991–1992 to 302 100 separations in 1998–1999; Table 2) [7].

If same day procedures undertaken within primarily private overnight facilities are included as an indicator of day procedure uptake in Australia, the proportion of same day procedures accounts for approximately 46% of patient separations in private hospital and day hospital facilities [8].

When same day procedures in public hospitals are examined, a similar level of growth is present over the same period (in the range of 29–43%). Although the proportion of these procedures is not as high as that relating to privately funded facilities, the sheer numbers of patient separations in the public sector indicates potential for expansion in same day treatments.

3.3. Patient days and length of stay

Patient separations for day procedures are equal to the total number of patient days for the same procedure [9]. Overnight stay patient days in both public and private facilities vary according to length of total admission (Table 3).

The number of same day patients treated within private overnight facilities during the period 1991–1999 has increased from 311 400 to 791 500 (61%) with a marginal increase in overnight stay patients from 4 579 900 to 5 249 200 (13%) [10].

For the period 1994–1995 to 1998–1999, anecdotal evidence shows that public facility patient days for overnight patients has decreased by around 4%. The proportion of same day separations in these facilities has increased by 7% which suggests substitution of same day separations for admissions involving an overnight stay is occurring [11].

Table 3 shows that the average length of stay related to overnight private patients in private hospitals has increased over the reference period. Yet when same day patients are included in these facility calculations, the average length of stay decreases, demonstrating that throughput has increased without a corresponding increase in what benefits would be paid by health funds.

Corresponding public overnight patient average lengths of stay have slowly decreased over the corresponding period, supported by the overall decrease in patient days. When same day patients are taken into account, the average length of stay decreases, further suggesting that the public sector has embraced day procedures as a means of increasing throughput but at a lower cost.

4. Types of free-standing day hospital facilities

Free-standing day hospital facilities have become a new factor in the delivery of private acute care in Australia. Being small in size, specialisation in services delivered has occurred. A number of areas have become the main domain of free-standing day facility services. Table 4 shows that general surgery and specialist endoscopy are clearly the main focus of most day hospital facilities [12].

Numbers of day hospital facilities providing services in each of these specialties have increased over time with the largest level of growth (around four-fold), evident in category 'other (a)', this being fertility management, plastic surgery and sleep disorders.

5. The future of day surgery in Australia

The historic level of increase in same day procedure use is expected to continue into the future. With advances in anaesthesia, technology and surgical techniques, many more procedures that currently require an overnight stay may be able to be undertaken on a same day basis without compromising safety or quality of care.

There are currently a number of reforms in the Australian private health industry which directly impact upon day procedures. These include the introduction of no or known 'gap' for hospital and medical charges for patients in private hospitals. The medical 'gap' is the difference between fees charged by medical practitioners for in-hospital medical services and the combined health insurance and Medicare benefits. Day hospital facilities may receive payments through agreements with health funds or from a Government determined minimum payment arrangement. These arrangements also allow for a so-called 'second tier' payment system whereby hospitals demonstrating high standards of care may receive benefit levels that are higher than the minimum payment arrangement.

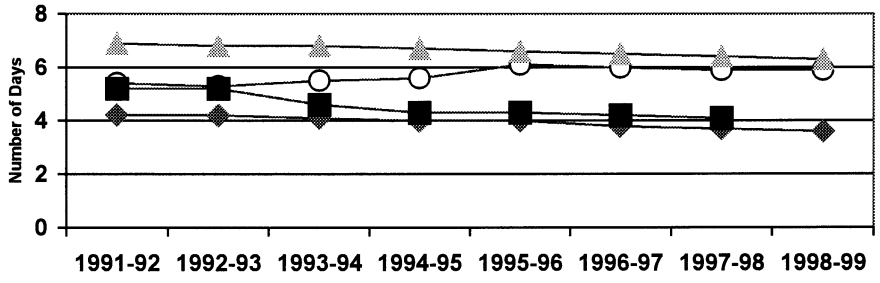
The Government is keen to broaden the scope of private health insurance to cover out of hospital care including day procedures administered in physician's rooms, extending the application of hospital in the home services for patients and examining the feasibility of using 'limited care accommodation' services for step-down recovery from the acute sector. Imperative to all changes is the care of the patient in terms of pain management after a procedure, and also allowing more advanced surgery to be performed on a day only admission basis, at an overall lower cost to purchasers and consumers.

It is clear that day surgery along with early discharge-type interventions can play a prominent role in increasing the efficiency of health care delivery and patient convenience and, as such, has a very big future in front of it. As well, there is a need to complete the spectrum of acute care from day procedures through to that of overnight stays.

Given these trends over the years the Government has commenced consultation with the industry on the option of categorising day only procedures to encourage a 'step down' of procedures to more cost effective settings and further support the use of day facilities as efficient and safe alternatives to overnight hospital care.

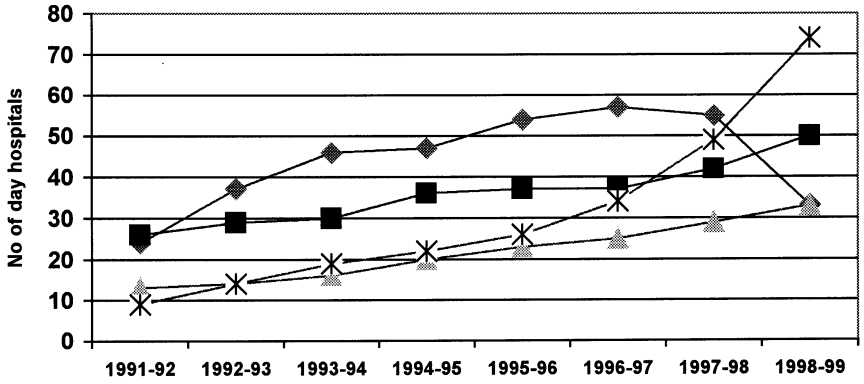
The Government believes the acknowledgement of both procedure complexity and types of facilities will allow for the expansion of day procedures, including allowances for this extension through office based

Table 3
Private and public overnight facilities average length of stay



—◆— Private, Overnight-stay patients; —○— Private, All patients (incl. same day); —▲— Public, Overnight-stay patients; —■— Public, All patients (incl. same day); Source, Australian Bureau of Statistics Private Hospitals 1991–1992 to 1998–1999 and Australian Institute of Health and Welfare Australian Hospital Statistics 1997–1998, Table 4.1.

Table 4
Types of day hospital facility growth



—◆—, General surgery; —■—, Specialist endoscopy; —▲—, Opthalmic; *, Other (a); Source, Australian Bureau of Statistics Private Hospitals 1991–1992 to 1998–1999.

surgery and extended recovery services. The Government has developed a proposal whereby benefits are payable for day procedures according to a patient classification system and facility categorisation. The proposal brings day procedures in line with those arrangements pertaining to overnight procedures thus facilitating the potential expansion of day only procedures.

The Government is continuing considerable consultation with the industry to ensure a refined proposal before implementation.

In addition, and with the support of the Australian Day Surgery Council, the Government is currently conducting trials with a number of funds and hospitals to explore the feasibility of a health professional employed by the hospital, in the absence of the treating medical practitioner, providing overnight certification for those patients who, for medical or social reasons, are unable to return to their normal domicile following a day surgery procedure.

These arrangements require the health professional employed by the hospital to discuss his/her recommendation for continued admission to occur with the treating medical practitioner. Such arrangements avoid having to recall the medical practitioner to personally authorise the extension of the patient's length of stay, and to also enable the payment of overnight benefits to be progressed without delay. These trials are a significant departure from the traditional arrangement in Australia, whereby it is customary for medical practitioners only to provide certification.

Payment under episodic/casemix/diagnostic related groups is currently being developed further especially where funds have agreements with facilities. However, at present, the basic health insurance payment basis in Australia is calculated on a per diem rate.

6. Summary

Population growth, utilisation of private acute care and a changing population age structure all point toward a change in the overall use of acute care (whether public or private). It would appear that, if not for the rapid uptake of day procedures by facilities whether free-standing or integrated within acute hospitals, a large increase in the costs associated with acute care would occur.

As such, the time has come for further changes to be made to the controls over same day procedures and facilities providing such services. Little change has occurred in recent times and any change proposed needs to encourage substitution, cost-efficiencies and also the quality and safety of patient care.

The outline of proposed changes put forward in this paper are designed to do just that. Barriers to benefit payments for overnight care at a lower level than that delivered in a standard acute setting will be removed. Imperative to all changes is the care of the patient in terms of pain management after a procedure, and also allowing more advanced procedures to be performed on a day only admission basis, at an overall lower cost to the purchaser and the consumer.

There are six areas of service delivery critical to all forms of health care reform, and day surgery is no exception. The six areas include:

- Safety.
- Sound clinical practice.
- Acceptance by professions.
- Benefits and acceptance by patients.
- Benefits and acceptance by carers.
- Cost effectiveness of trials [13].

In summary, both sectors of acute care have greatly embraced day procedures as a means of patient treatment. Associated with advances in medical technology,

more and more of what is traditionally overnight stay treatment will eventually be undertaken more safely and effectively on a day only basis. This can be expected to lead, in many instances, to the use of multidisciplinary approaches to assist in patient recovery following same day surgery.

References

[1] Private Health Insurance Administration Council. Quarterly Statistics, Hospital Table Membership and Coverage, Ancillary Table Membership and Coverage Table 1, December 2000.
[2] Private Health Insurance Administration Council. Quarterly Statistics, Hospital Table Membership and Coverage, Ancillary Table Membership and Coverage Table 3, December 2000.
[3] Commonwealth of Australia. Industry Commission, Private Health Insurance Report No. 57:22–23, 28 February 1997.
[4] Commonwealth of Australia. Industry Commission, Private Health Insurance Report No. 57.25, 28 February 1997.
[5] Department of Health and Aged Care records.
[6] Australian Bureau of Statistics. Private Hospitals, Publications 1997–1998 and 1998–1999, Table 22.
[7] Australian Bureau of Statistics. Private Hospitals, Publications 1991–1992 through to 1998–1999, Table 27 and Australian Institute of Health and Welfare, Australian Hospital Statistics 1997–1998 Table 4.1, pp. 39.
[8] Australian Bureau of Statistics. Private Hospitals, Publication 1998–1999, Tables 1 and 2, pp. 8–9.
[9] Australian Bureau of Statistics. Private Hospitals, Publication 1998–1999, Table 1, pp. 8.
[10] Australian Bureau of Statistics. Private Hospitals, Publication 1998–1999, Table 1, pp. 8.
[11] Australian Institute of Health and Welfare. Australian Hospital Statistics 1998–1999, Table 4.1, pp. 42.
[12] Australian Bureau of Statistics. Private Hospitals, Publications 1991–1992 through to 1998–1999.
[13] Commonwealth of Australia. Healthcare Management Advisors, Report of the National Evaulation—July 2000. Evaluation of Private Sector Based Early Discharge and Hospital in the Home Trials, pp. X–XV.