

The Commonwealth Government and day surgery in Australia

P Callanan

Health Insurance Section, Commonwealth Department of Human Services and Health,
Canberra, Australia

The Commonwealth Government of Australia has taken an active role in promoting day surgery. In this paper I will outline the present situation before outlining the future direction of day surgery in Australia.

Australia's healthcare system

A federal system of government exists in Australia. Under the Constitution, the Commonwealth has legislative power over health insurance. In addition, the Medicare agreements with the states and territories have enabled the Commonwealth to oversee the provision of a universal scheme of healthcare. The relevant Acts are the National Health Act 1953 and the Health Insurance Act 1973. States retain the residual power over health services.

All Australians have equal access to basic healthcare needs under Medicare. Every Australian has the choice, on admission to a public hospital, of electing to be treated as a Medicare patient or as a private patient. Medicare patients receive accommodation and medical treatment by hospital-appointed doctors without charge. Private patients are responsible for the payment of both the hospital charges and doctors' fees for medical services, subject to insurance rebates. The main purpose of maintaining private health insurance is to obtain benefits towards costs associated with services and facilities not available under Medicare, such as doctor of choice in hospital, preferred levels of hospital accommodation and coverage for ancillary services such as aids and appliances.

The Commonwealth does not exercise any controls over private hospital facilities. They are autonomous organizations, recognized for insurance benefit purposes,

and free to set their own fees. At present, some public and private hospitals have day surgeries geographically within the hospital, while a number of free-standing private day surgeries exist.

Unlike the United States, Australia treats day surgery patients as hospital patients. As a consequence of being administratively treated as a hospital patient, the public patient in a day surgery centre receives treatment free of charge. A private patient receives benefits under the health insurance basic table to cover day surgery costs, plus amounts from Medicare and the private health insurance funds to cover the scheduled fee for doctors' services.

A health insurance basic table (regulated by the Commonwealth Government) is primarily designed to cover public hospital charges for same-day or overnight shared ward accommodation as a private patient. However, the basic table also applies to private hospitals and day hospital facilities, although patients who utilize private facilities tend to purchase a level of insurance beyond the basic table, as the charges raised by private facilities are usually higher than the benefits contained in the basic table. This additional insurance is not regulated and health insurance organizations are free to set their own conditions.

Day surgery in Australia

Although day surgery, as such, has been undertaken in hospitals for some time, it was not until the early 1980s that this delivery of healthcare became formalized in Australia. In 1980 the Royal Australasian College of Surgeons and the Australian Association of Surgeons, together with the Faculty of Anaesthetists of the College and the Australian Association of Anaesthetists, estab-

Accepted:

Correspondence and reprint requests to: P Callanan, Health Insurance Section, Commonwealth Dept. of Human Services and Health, PO Box 9848, Canberra ACT 2601, Australia

lished a working party on day surgery, which published its first manual of standards in 1981.

1982 saw the first private free-standing hospital facility opening in Australia and since then there has been a spurt of growth in this area and there are now 101 such facilities operating throughout the country.

The College of Surgeons' working party has increased in size and membership and today is known as the National Day Surgery Committee. This Committee has provided much valuable advice to the Commonwealth and continues to do so. A list of its members is in the Appendix.

The Commonwealth Government is keen to encourage the greater use of day surgery in those cases where it is clear that it is a safe and effective alternative to overnight hospitalization. As always, the Commonwealth's prime concern in the provision of health services is the needs of the patient. The Commonwealth considers that day surgery offers significant benefits to many types of patient and is particularly beneficial to children, who no longer have to undergo prolonged separation from their family in times of illness. Day surgery also offers the opportunity to free hospital beds for those people awaiting more complicated surgical procedures and requiring longer-term hospital care. Of course, we are not averse to the obvious potential reduction in healthcare costs either!

The Commonwealth's commitment to and recognition of the value of day surgery has been demonstrated in two major ways. The first is through the basic table of private health insurance, which affects privately insured patients in both the private and public hospital sector. The second is through the Medicare agreements, specifically the Medicare incentives package.

Basic table and day surgery

Through the private health insurance sector, and with the potential benefits of day surgery in mind, in December 1989 the Commonwealth Government introduced the day arrangements into the health insurance basic table by amendments to the National Health Act 1953. These arrangements provide for differential levels (bands 1-4) of facility benefits from the basic table. The benefit for the top level (band 4) is equal to the overnight basic table benefit. This new costing structure provides financial incentives for hospitals to use day-only surgery rather than admit patients for a night in hospital.

The legislation provides for three kinds of professional medical attention. The type A list consists of professional attention that would normally require overnight hospitalization. The type B list comprises procedures that should be done on a day-only basis. The exclusion list, known as the type C exclusion list, identifies procedures that should not require hospitalization. This has been a crucial element in endeavouring to ensure that the growth in the use of day surgery occurs from transferring overnight hospitalization to day procedures and not from services normally rendered to hospital outpatients or in doctors' rooms. However, the system is flexible,

allowing a doctor to certify that a patient who would normally fall within the exclusion list should actually be treated in the day surgery sector. A similar certification process occurs in moving a day surgery patient to overnight hospital care.

Full details of the day-only arrangements are available in the Day Only Procedures Manual, which is published by the Department of Human Services and Health. Copies of the manual can be obtained by writing to the Health Insurance Section, Department of Human Services and Health, PO Box 9848, Canberra ACT 2601, Australia.

Medicare agreements

The second field where the Commonwealth has shown strong support for day surgery is in the Medicare agreements. The Medicare agreements contain the same day-only arrangements that exist for private patients – that is the banding arrangements and the type C exclusion list and certification. This means that these arrangements are now the same for both public and private patients throughout Australia.

For some years now the Commonwealth and states have used the Medicare agreements to encourage greater efficiencies in the public hospital system through substitution of in-hospital effort with more cost-effective treatment modes. Since 1988, the Medicare incentive package (MIP) has targeted three areas: day-only procedures, early discharge for post-acute patients and community-based palliative care services. The day-only component of the MIP has been aimed at encouraging day surgery in the public sector and the provision of medical services on a day-only basis. From 1988/9 to 1992/3, the Commonwealth spent \$58 million on 65 projects concerned with the development of day procedures. These projects used funds to:

- initiate dedicated programmes for day procedures;
- purchase capital equipment; and
- promote day surgery through the designation of dedicated space for either theatres, recovery, or patient administration, or additional dedicated sessions.

Earlier this year, MIP was subjected to formal evaluation by an independent consultant. The evaluation report noted that over the first four years of the five-year programme:

- 28% of the day procedure projects were mainstreamed to become part of normal hospital practice; and
- the funded day surgery projects that are most effective are those in which day surgery is provided in dedicated or 'stand-alone' facilities.

The consultant observed that, to be effective, a dedicated operating theatre would need to perform around 1500 cases a year. The comparable figure for an endoscopy room was projected at around 2000 cases per year.

In 1991/2:

- there were 1 300 966 day-only admissions to hospitals in Australia, including 831 277 admissions to public hospitals and 469 689 admissions to private hospitals; and
- of the 831 277 admissions to public hospitals, 632 502 were public patients (76%), 188 284 private patients (23%), and 10 491 compensables and ineligible patients (1%).

Commonwealth/state support for day surgery and the provision of medical services on a day-only basis is to continue over the five years of the current Medicare agreements. It is projected that over the next four years, the Commonwealth will spend about \$55 million on day surgery projects.

Future directions

Magazine/journal articles

The Department of Human Services and Health envisages using 'user-friendly' articles in weekly magazines and journals and other forms of media publicity to inform health administrators, hospital executives, nursing and ancillary staff and patients of the benefits of day surgery.

It is essential that patients, in particular, are made aware of day surgery and its potential benefits. Moreover, many doctors need to be informed of the option of day surgery and the certification requirements that go with it. Review of the day-only arrangements has revealed medical practitioners' reluctance to complete paperwork.

23-hr hospital patients

The Department is also aware that many patients who have day surgery are hospitalized overnight purely because the surgery was scheduled for late afternoon. The Department appreciates that not all day surgery can be scheduled to ensure that patients are discharged on the same day.

To counter this, the Commonwealth is considering creating a short-stay category of private patient. This patient would spend less than 24 hr in a facility and be designated a day patient and day facility benefits paid accordingly. If successful it can be expected that the category will also apply to public patients.

Early discharge for post-acute patients

The Commonwealth is particularly interested in programmes which will demonstrably reduce lengths of hospitalization, without jeopardizing patient health or disadvantaging patients in any other way. In 1992 the Department supported a pilot early discharge programme under the health insurance basic table, which aimed to return patients to the familiarity and comfort of their own homes shortly after hospitalization – safe in the knowledge that professional nursing support was readily available for home treatment.

The pilot programme, run by a private organization, was expected to run for 18 months but only lasted for 6 months. The reasons cited for the reduced length of the pilot programme included a lack of cooperation by certain medical specialists.

Despite the limited success of the 1992 pilot programme, the Department has a continuing interest in supporting these and other types of innovative programmes (e.g. recovery care centres) and would consider introducing a basic table benefit for such services. Such programmes would provide a support system for more involved day surgery.

Basic table changes

The basic table will have to change its shape to take the casemix initiated diagnostic related groups (DRGs) into account. It may also be affected by the current Commonwealth Government review of the health insurance arrangements. We do not know precisely what the basic table will look like in the future, but you may be sure that there will be plenty of health industry consultation before the final table is introduced.

Ambulatory care

In July 1993 the Australian Health Ministers' Conference (AHMC) agreed to start a process of ambulatory care reform in the public hospital system. Ministers endorsed a two-year research and development programme to develop an agreed framework for the organization, delivery and funding of hospital-related ambulatory services.

The ambulatory care research programme objectives are to:

1. Develop an agreed conceptual framework for the operation of hospital-based ambulatory services which:
 - (a) take account of the relationship between costs and services across inpatient, outpatient and community services;
 - (b) promote continuity of patient care by encouraging coordination of services over an episode;
 - (c) safeguard teaching and research;
 - (d) reduce incentives for under- and over-provision;
 - (e) continue the tradition of convenient patient access to a broad range of services; and
2. Within the agreed framework, undertake pilot projects for each state to gather essential information and test new approaches for counting, classifying and paying for hospital ambulatory services.

Key features of the ambulatory care framework will be tested and developed over the next two years, through the Ambulatory Care Research and Pilot Programme. The programme is currently at an early stage, with most of the first year research projects expected to commence in January 1994.

Distinct day surgery services will be identified through the research programme, but are not considered to be within the scope of ambulatory care services. This is due to the fact that day surgery is regarded as an inpatient service in Australia.

Application of new technology

The creation of new technology such as keyhole surgery (new laparoscopic techniques) and more refined anaesthetics can only improve the provision of day surgery.

Conclusion

The Commonwealth is involved in day surgery in both the public and private spheres of healthcare. The Government's establishment of the Medicare incentive package and its regulation of the basic table has encouraged the growth of an alternative to overnight hospitalization. With the cooperation of the states, the medical profession and with the guidance of an expanded National Day Surgery Committee, this encouragement should see the further expansion of day surgery centres. The Commonwealth is also eager for other early discharge programmes to be initiated.

Early discharge programmes contain advantages for all involved in the provision of medical treatment. Patients have the option of staying in their home environment instead of an alien hospital environment. Moreover, the risk of cross-infection is avoided. Hospitals have an increased throughput. However, the Com-

monwealth's continued support for day surgery and its future expansion is not simply idealistic, it is also financial. The patient will not be forced to incur the cost of spending the night in hospital when it is not necessary or desired. With such advantages on all sides, the continued growth of day surgery is assured.

Appendix – National Day Surgery Committee

Australian Association of Surgeons
Royal Australasian College of Surgeons
Australian and New Zealand College of Anaesthetists
Royal Australian College of Obstetricians and Gynaecologists
Otolaryngological Society of Australia
Royal Australian College of Ophthalmologists
Neurosurgical Society of Australasia
Australian Society of Plastic Surgeons
Australian and New Zealand Association of Urological Surgeons
Australian Orthopaedic Association
Australian Association of Paediatric Surgeons
Australian Dental Association
Australian Medical Association
Australian Private Hospitals Association
Australian Health Insurance Association
Health Insurance Commission (Medibank Private)
Australian Hospital Association
Australian Association of Day Surgery Centres
Gastroenterology Society of Australia

7th Annual Clinical Office Phlebology Workshop '94

Encino, California, USA

Features:

- Clinical and Non-Invasive Diagnosis of the Venous Systems
- Truncal Varicose Veins: Comprehensive Sclerotherapy *versus* Invaginated Stripping and Ambulatory Stab Avulsion Phlebectomy
(HOOK PHLEBEXTRACTION)
 - Sclerotherapy for Spider Veins
- CVI: Etiology and Management (CIRCAID DRESSING AND PARATIBIAL FASCIOTOMY)

SEPTEMBER

23-24

NOVEMBER

18-19

For further information please contact: Gabriel Goren, MD, Vein Disorders Center, 16311 Ventura Boulevard, Suite 505, Encino, CA 91436, USA

Tel: +818 905 5502

Fax: +818 905 6092