



Improving the viability of the Australian healthcare system: The Day Hospitals Contribution



Day Hospitals
AUSTRALIA

Increasing healthcare costs are creating challenges worldwide. All stakeholders in Private Healthcare must reduce costs in any way possible to avoid or delay major reform. Increased utilisation of day and short-stay hospitals is part of the solution, offering savings of up to \$508M per annum.

[Day Hospitals Australia Ltd](#)

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Executive Summary – for the attention of Medical Specialists

The private health care sector is a key component of Australia’s overall health care system. It reduces the cost of operating the public health care system in each state and territory by efficiently undertaking large volumes of common treatments at the 640 private hospitals in Australia. This is funded by a combination of the patient’s private health insurance premiums, government rebates, and patient out-of-pocket costs.

It is widely acknowledged^{1,2,3} that Australia’s aging population and increasing costs are reducing the consumer appeal of private health care. The actuarial balance is shifting against private health insurers over the long term. While at present, purchase of private health insurance policies is increasing, those taking out new policies are older and more likely to need to make a claim on their health insurance.

Substantial reform will be needed at some point in the future to allow consumers to continue to benefit from the current mixed model of health care provision. Such reforms are likely to be politically difficult for whichever government that implements them. There are always winners and losers in a regulator “top down” solution, with unintended consequences that negatively impact on some patients. . A collaborative “bottom up” approach is more likely to provide a better patient outcome, with preservation of our health care system. All stakeholders must focus on cost savings that are possible now. Day Hospitals Australia proposes that more appropriate utilisation of Day and Short Stay Hospitals is an important component of such cost saving.

Definition of a Day Hospital - A day hospital is a licenced and accredited free-standing facility, physically separated from and not integrated with an overnight hospital, that admits patients for medical and/or surgical treatment which is conducted within a 23-hour period.

The free-standing Day Hospital sector is a cost-effective platform for a growing number of treatments and procedures. As a result, all payers, particularly private health insurers, pay substantially less to day hospitals for the same procedure than they pay to larger overnight hospitals. This is backed up by publicly available data verifying that day hospitals are demonstrably cost effective venues of care for appropriate treatments and appropriate patients. Available annual savings are over \$508M.

Day Hospitals Australia proposes the following actions to realise these potential savings:

- Consumers should be supported by health insurance policies which encourage admission to cost efficient venues of care, where both surgeon and anaesthetist agree that this is in the best interests of the patient. Venue of care remains the admitting specialist’s choice, in order to ensure that the patient is in an appropriate facility for his or her medical condition.
- Specialists should be supported by medical peak bodies (such as AMA and AOA), to consider use of day and short-stay hospitals for a higher proportion of same-day procedures, where this is appropriate for the patient’s condition.

¹ The Australian Medical Association, 2020, The AMA Prescription for Private Health Insurance

² Grattan Institute, 2019, The history and purposes of private health insurance

³ PwC, 2017, Reimaging Healthcare in Australia

- All stakeholders must cooperate on expanding the medical scope of day and short-stay hospitals to transition a wider range of procedures to better value venues of care. This may require encouraging or facilitating trial and implementation of successful models of care from comparable international health systems.

Implement a classification system for MBS items which can be provided in standalone day hospitals that are cost efficient centres of care, where there is no medical or geographical reason preventing this to occur. The data resulting from this classification system, will provide evidence of the cost effectiveness of standalone day hospitals. This classification to be developed collaboratively by stakeholders and to be assessed for its cost benefit.

Healthcare is a growth industry, and growth will continue as the population ages and increases. The goal of Day Hospitals Australia is to ensure that the private component of healthcare delivery remains viable over the long term. Our core suggestion is to cooperatively stream patients into the lowest cost venue of care appropriate to each patient's needs and to maintain highest quality of care. The venue of care decision remains with the admitting doctor. The doctor's choice of venue tailored to patient's needs must be preserved.

Cost Savings

Introduction

Private Healthcare can deliver immediate and significant cost savings through:

- higher use of cost effective venues of care (in particular day and short-stay hospitals) for procedures that are currently done as same day procedures in overnight hospitals – **“Lower Procedure Cost”**
- further development of short-stay models of care that allow a wider range of procedures to be safely undertaken in day and short-stay hospitals – **“Model of Care Innovation”**

Lower Procedure Cost

Introduction

For any given procedure, each private hospital is paid a different amount by private health insurers (PHIs) and other payers for providing the venue, staff and equipment. In general, larger hospitals are paid more, while smaller hospitals are paid less. There is also wide variation in payment amounts by state, between the various PHIs, and even variation in payment amounts between hospitals of the same type in the same state.

This variation is for two principal reasons:

- Larger hospitals demand higher rates to compensate for the costs of operating intensive care beds and emergency departments.
- Day Hospitals provided a price advantage when the first stand-alone facilities were developed in Australia three decades ago.

This price differential means that PHIs are paying more for many procedures than necessary when their members are admitted to a large hospital for a simple procedure.

A 24 hour hospital is appropriate for patients who, due to their medical condition, need the backup services that such a hospital provides, or who due to their location have limited access to private healthcare nearby. Choice of hospital must remain at the discretion of the admitting practitioner, however for many procedures the proportion of patients in one or both of these categories is small. The need for a “higher care” facility is usually apparent pre-operatively.

Evidence & Analysis

Both Hospital Casemix Protocol (HCP) and Private Hospital Data Bureau (PHDB) datasets clearly demonstrate that day hospitals are better value than overnight hospitals.

[Appendix One](#) details a calculation of the potential savings available to the private healthcare system through increased use of day hospitals. This calculation is based on PHDB data from Financial Year 2019-2020 and incorporates same-day episodes of care coded to those 32 DRGs for which more than 90% of the admissions to overnight hospitals are same-day.

Out of these 32 DRGs, it is useful to focus on the highest volume DRGs here:

DRG	AR-DRG Description	SD Vol in ON	Av. Hospital Charge ON	Vol in DH	Av hospital charge DH	Price diff
R63Z	Chemotherapy	251 561	\$705.67	82 153	\$520.01	36%
L61Z	Haemodialysis	124 034	\$444.89	80 946	\$347.48	28%
C16Z	Lens interventions	70 773	\$2540.62	91 227	\$2268.92	12%
G47C	Gastroscopy, Minor Complexity	61 360	\$861.67	40 195	\$469.66	83%
G48B	Colonoscopy, Minor Complexity	137 164	\$1107.04	75 726	\$696.44	59%
G46B	Complex endoscopy, minor com	92 411	\$1258.53	56 387	\$765.93	64%
L44B	Cystourethroscopy	26 080	\$1061.50	2 536	\$719.31	48%

Table 1: Selected high volume DRGs⁴

Notes on this table:

“SD Vol in ON”	Number of treatments carried out on the same day in overnight hospitals
“Av. Hospital Charge ON”	The average amount charged to health funds by overnight hospitals for that treatment
“Vol in DH”	The number of treatments carried out in same-day hospitals
“Av hospital charge DH”	The average amount charged to health funds by day hospitals for that treatment

Outcomes & Commentary

Payers, predominantly the PHIs, are paying on average over 40% more in overnight hospitals than they could be paying for the same service in a day hospital. Based on the volume of procedures carried out on a same-day basis in overnight hospitals, there is scope to reduce hospital benefit outgoings by substituting the venue of care.

It is acknowledged that local access for specialised services may be an issue – that in some locations, an overnight hospital may be the only option for a given treatment due to:

- 1) availability of specialised equipment,
- 2) availability of specialised staff and space (e.g. ICU back-up), or
- 3) distance to the nearest day hospital.

Any program to encourage admission to day hospitals will improve the first two in the short term, and the third point over the longer term.

⁴ Private Hospital Data Bureau, Department of Health, 2021, The PHDB Annual Report 2019-20

Potential Savings

	Savings
All payers	\$343 million
PHIs Only	\$277 million

Table 2: Potential Savings

[Appendix One](#) details the calculation of potential savings, with reference to the most recent Private Hospitals Data Bureau (PHDB) report. This PHDB data sets out a range of hospital cost components by AR-DRG code, AR-DRG version, state, and hospital type (overnight or day). This allows direct comparison of the difference in cost between day hospitals and overnight hospitals for specific procedures or groups of procedures. It also allows a calculation of the cost savings available if patients were admitted to day hospitals for these procedures, instead of overnight hospitals.

We acknowledge two minor drawbacks of this data:

- The report 2019-2020 is affected by comparison to previous years by elective surgery restrictions due to the coronavirus pandemic. This has the effect of reducing the apparent volume of savings, but it does not detract from the validity of the conclusions.
- The PHDB data includes some activity not funded by the PHIs. We suggest that this proportion is small enough not to affect the validity of the conclusions. The alternative, Hospital Casemix Protocol data, includes activity outside private hospitals. This point is further addressed under "[Calculation](#)" in Appendix One.

There are several factors which prevent the PHIs from realising the entirety of these savings:

- There are many Day Hospital-PHI pairs without a contract (Hospital Purchaser-Provider Agreement - HPPA), which is a disincentive for patients who may be liable for hospital gaps, and substantial medical gaps in the case of one private health insurer.
- The PHIs, with one exception, do not seek to influence a specialist to admit a patient at one hospital over any others.
- In most cases, the admitting specialist decides where to treat his or her patient. There are many reasons for specialists not choosing a day hospital:
 - The specialist is not credentialed at any day hospitals
 - There is a chance that the patient may require an overnight stay or may require the clinical back-up typically only provided by a larger overnight hospital with a critical care unit ("category f").
 - It may be more convenient for the specialist in terms of completely filling a list at one facility, or in terms of travel time.
 - One PHI removes access to its medical gap scheme for uncontracted hospitals, providing a large disincentive for practitioners to admit patients there.

Model of Care Innovation

Another category of potential savings is those procedures where the Australian model of care results in a longer length of stay than experienced in comparable overseas systems (e.g. USA, UK).

Practitioners in these jurisdictions have been transitioning patients to shorter-stay, smaller venues of care over the past couple of decades. This trend is starting to appear in Australia, to the benefit of the private healthcare system.

One example of this is joint replacement surgery. Significant proportions of patients in the UK and USA are discharged on the same day from joint replacement surgery. One study from the USA predicts that by 2026, over 50% of all total joint arthroplasty patients will be discharged same day⁵. A small number of Australian orthopaedic surgeons and anaesthetists have adopted a similar model of care and are discharging some patients after one night or in exceptional cases, same day. This requires some level of patient selection and possibly adjustments to anaesthetic and surgical approach.

Knee and hip replacements absorb a very large and growing proportion of PHI outgoings. The PHDB Report from 2019-20 suggests that this amounted to 57,000 separations and over \$1.1 billion in outgoings to overnight hospitals (not including medical fees)¹⁵. This report further records 51,000 uncomplicated hip and knee replacements at a cost of almost \$1B in hospital charges, or \$19 283 per episode inclusive of prostheses. Transitioning 50% of THA and TKA patients to short-stay hospitals has the potential to save \$75M.

Another common feature of short-stay models of care in use in the UK and Canada is the low incidence of post-surgery inpatient rehabilitation by comparison to Australia. Rehabilitation is a large expenditure item for private health insurers but is generally less used by practitioners utilising a short-stay model of care. More cost efficient home care rehabilitation models are available and already established in Australia.

The Australasian Rehabilitation Outcomes Centre (AROC) reports 24,780 episodes of joint replacement rehabilitation in 2020, of which 87.5% or 21,700 took place in the private sector⁶. The average length of stay for these cases was 11 days. In total, PHDB data reports 58,422 THA and TKA cases for 2019-2020, which implies a referral rate to private inpatient rehab of approximately 42%. This was a 10% decline in volume compared with the previous 12 months.

Naylor (2017 – MJA) reports an average cost of \$8400 for a 12 day LOS⁷. We assume that the combined impacts of five years of contract indexation and a one-twelfth reduction in length of stay balance out to leave the average cost at \$8400.

Inpatient rehabilitation following total hip or total knee arthroplasty therefore costs the PHIs approximately \$180M annually. Naylor and others make a case for different models of care in post-

⁵ Shankar Narayanan, MD; Thomas Schmicker, MD; and Ran Schwarzkopf, MD, MSc, Is Same-Day Discharge Safe for Total Joint Arthroplasty Patients? ICJR, November 2021.

⁶ Australian Rehabilitation Outcomes Centre, 2021, The state of rehabilitation in Australia in 2020

⁷ Naylor, JM, 2017, The value of inpatient rehabilitation after uncomplicated knee arthroplasty: a propensity score analysis, MJA 207 (6) j 18 September 2017

surgical rehabilitation for many patients⁸, which may provide an opportunity for significant savings. We estimate that savings of half of this amount is possible.

Savings	
Joint replacement	\$75 million
Less IP rehab use	\$90 million

Table 3: Potential Savings – short stay initiatives

Joint replacement is just one example of this trend. Many other short-stay models of care exist and could be implemented in order to treat more patients in cost effective venues of care and thereby improve the viability of private healthcare.

⁸ Schilling, C, 2018, Predictors of inpatient rehabilitation after total knee replacement: an analysis of private hospital claims data, MJA 209 (5) j 3 September 2018

The Patient Perspective

Industry benchmarking studies indicate that patients are highly positive about their episode of care within day hospitals. Patients report that they find smaller facilities substantially less intimidating than larger hospitals. There are a variety of reasons for this, relating to the smaller scale of these facilities:

- Patient familiarity with specific day hospital staff – where often the nurse that called the patient pre-admission, also admits that patient, discharges that patient and follows up with them post-discharge
- The overall lower level of traffic within a smaller facility
- An explicit drive towards a calmer atmosphere within the hospital
- A strong supportive commitment to efficient discharge

There is also a range of other improved outcome and convenience factors:

- Patients face a reduced risk of infection due to shorter stay, and absence of patients with high-risk profiles
- Evidence shows that patients recover from several procedures better in their own homes⁹
- Discharge to home means that patients are in a familiar environment, reducing the risk of disorientation and falls.
- total length of stay at the hospital can be shorter due to less complexity of the scheduling and admissions processes
- parking can be easier at a smaller facility, partially due to location
- the location may be more convenient for patients
- day hospitals are often co-located with other health services, offering a wide range of services at one location.

Many day hospitals are recording and reporting Patient Reported Experience Measures to drive improvement activities.

⁹ Mallinson, T. R. et al., 2011, A Comparison of Discharge Functional Status After Rehabilitation..., Archives of Physical Medicine and Rehabilitation, Vol 92, Issue 5, May 2011, 712:720.

The Specialist Perspective

Most specialists practicing in the private sector are credentialed at several private hospitals. This means that they have some degree of choice in where to admit their patients. There are number of reasons why specialists choose to practice at day facilities, instead of larger overnight hospitals.

A recent study elicited the following key reasons for surgeons to choose a private hospital (in order of importance):

Reason	Commentary
Availability of theatres	This agrees with anecdotal data that regular list times can be difficult to secure within large overnight hospitals for some specialties, and that theatre space/time is in short supply in some areas.
High standard of care	Day Hospitals are held to the same National Standards as larger facilities and are able to attract highly qualified and experienced staff due to better working conditions (e.g. no shift work). It is easier to schedule the same theatre team for every list of a given surgeon/anaesthetist partnership, due to the lower complexity of the smaller operating environment. This constant team leads to better patient outcomes.
Attitude of staff and management	Specialists find access to the most senior staff and decisionmakers within the hospital much easier within the day hospital environment. This access is naturally more difficult for an individual surgeon within a large hospital.
Location	With a smaller footprint (1000m ² - 2000m ² in many cases), it is easier to establish a day hospital in locations convenient to patients and specialists.
Equipment	Often, each specialty that is hosted at a particular hospital requires corresponding specialist equipment (e.g. endoscopes for gastroenterology, phacoemulsification machine for ophthalmology) or specialised space (hybrid theatre for interventional radiology). Despite smaller resources, day hospitals are often highly focused – providing a very high-quality venue with top-quality equipment for a small number of specialties. Further, as each practitioner has better access to the decision-makers within the hospital their needs are generally better met.

Table 4: Day Hospital advantages for specialists

One argument specialists or overnight hospital operators may have against using day hospitals is the relative lack of in-house facilities if a patient requires further care, however recent industry data demonstrates that admission to an overnight hospital following same day treatment is extremely rare, the percentage of unplanned or emergency patient transfers from a day hospital to an acute sector hospital remains low at 0.07% of total admissions (QPS data August 2021)

The Private Health Insurers' Perspective

PHIs are concerned about their future. The cost and volume of treatments that they fund is increasing, and a ministerial cap on premium price rises limits increases in revenue per policy.

Health insurance premium increases are often compared in both media articles and industry papers with increases in the general consumer price index (CPI). This simple comparison shows that over the past couple of decades, health insurance premiums have increased at approximately double the rate of the price of other goods and services (Figure 1¹⁰). Further analysis below outlines the reasons for this higher growth rate.

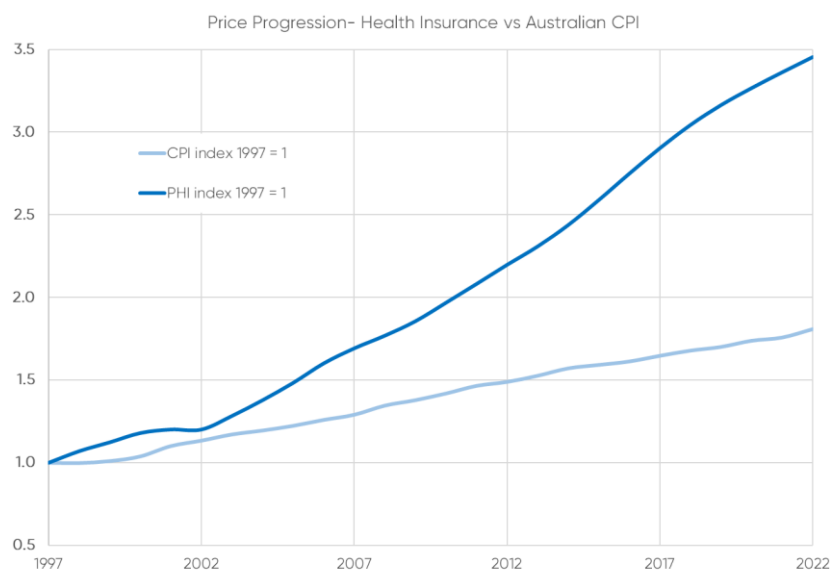


Figure 1: Comparing Health Insurance Premiums with general CPI

Due to the way private health insurance is structured (community rating, voluntary with incentives, risk equalisation), a health insurance policy is an unattractive proposition for some. Health insurers try somewhat in vain to make their product attractive to younger people in order to have them subsidise the health care of older members. This can be contrasted to Bismarck models (such as Germany, Netherlands, and Japan), where purchase of a health insurance policy is in most cases mandatory for all residents.

Despite a large number of adjustments to the private healthcare legislation and regulations, the trend until recently has been for a reduction in the proportion of Australian residents with private health insurance. After almost five years of declining membership by proportion of the population, the last five quarters have exhibited an increase in coverage (Figure 2)¹¹.

¹⁰ Data from Department of Health, 2021, Average annual price changes in private health insurance premiums, dataset accessed at [Average annual price changes in private health insurance premiums | Australian Government Department of Health](#) and Australian Bureau of Statistics, 2022, Consumer Price Index, dataset accessed at [Consumer Price Index, Australia, December 2021 | Australian Bureau of Statistics \(abs.gov.au\)](#)

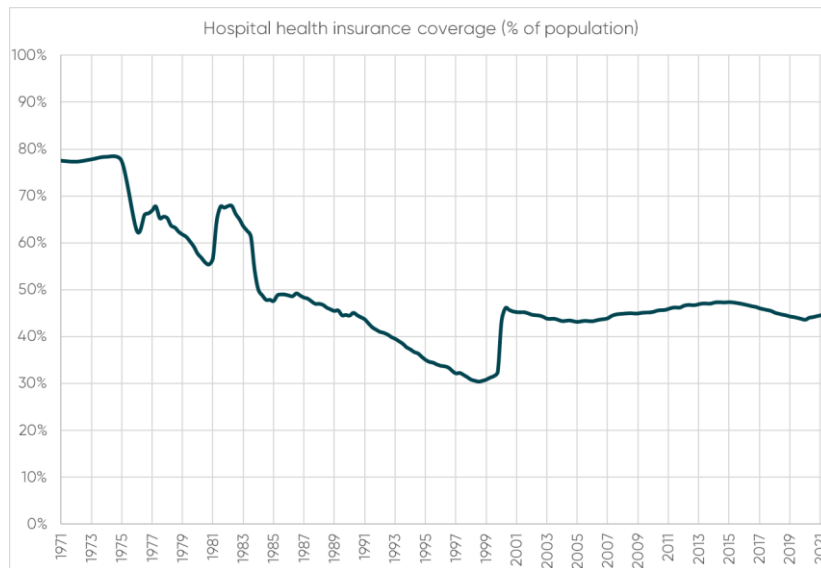


Figure 2: PHI coverage (%)

However, the market for private health insurance is growing alongside a growing population. The population has grown by 35% over the past two decades (to 1 July 2020), and the number of insured people has increased by 40% over the same period (Figure 3)¹¹.

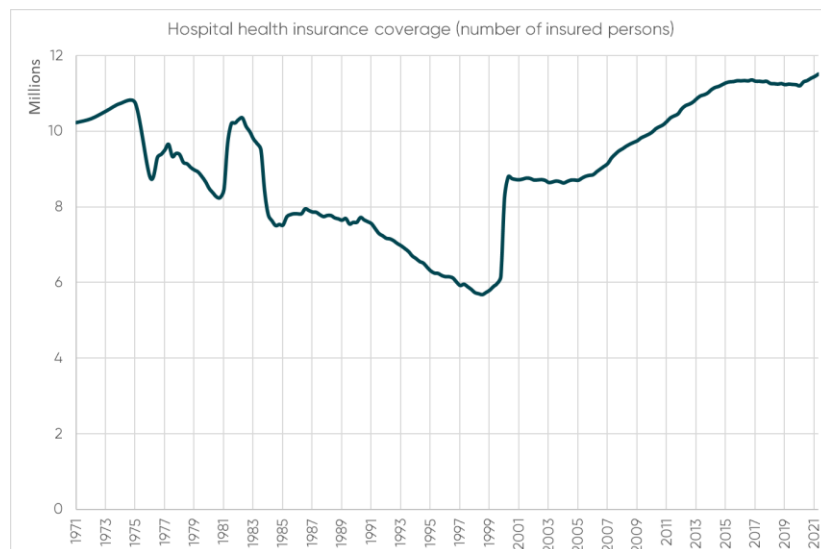


Figure 3: Number of Insured persons

The average age of those covered by health insurance policies is increasing, meaning fewer young people to subsidise the health care of older policy holders. The last adjustment with a large impact was Lifetime Health Cover introduced on July 1st, 2000. As a result, many younger Australians

¹¹ Australian Prudential Regulation Authority, 24 November 2021, Quarterly Private Health Insurance Membership Trends September 2021, <https://www.apra.gov.au/quarterly-private-health-insurance-statistics>

bought health insurance policies, increasing the insured population by approximately 3 million people, and reducing the average age of an insured person by just over two years. Since then, the average age has increased again by almost five years above the mid-2000 low (Figure 4)¹¹.

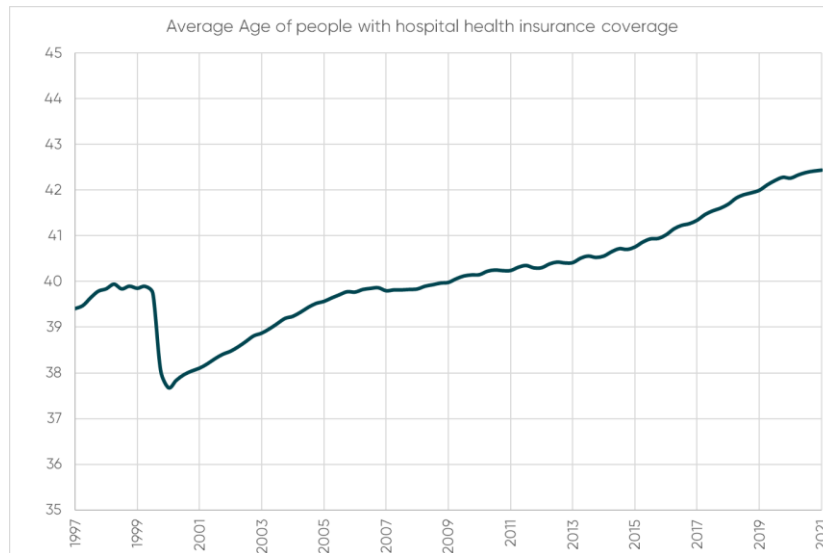


Figure 4: Average age of insured people

Volume impacts on PHI outgoings

While it is clear that PHIs have enjoyed premium increases that have been substantially higher than CPI over the past two decades, they have also been required to pay for increasing volumes of episodes of care in public, private day and private overnight hospitals (Figure 5).

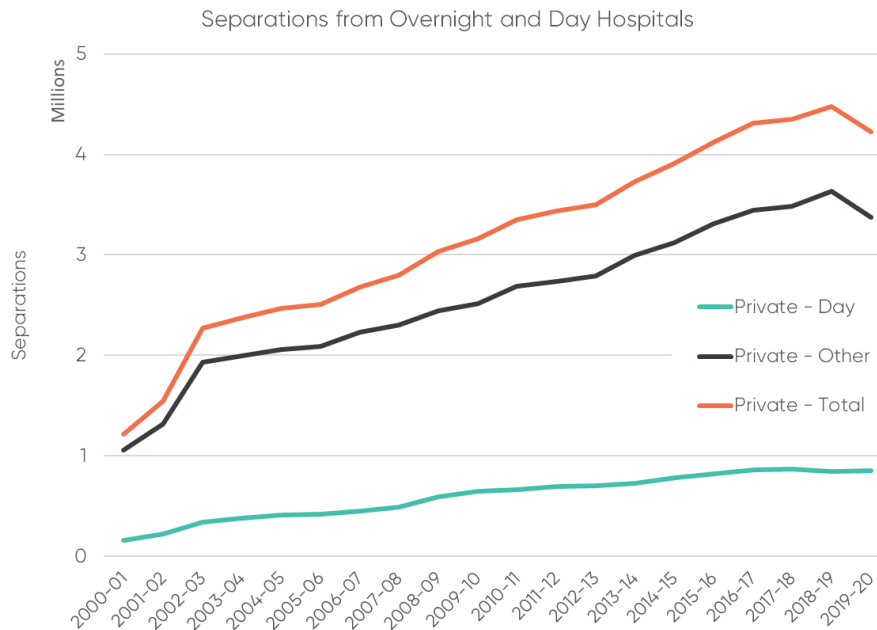


Figure 5: Volume growth - two decades¹²

Private Health Insurer Contracting

Current situation

PHIs are under no obligation to contract with any particular hospital. It is clear from our analysis that PHIs are more prepared to contract with some types of hospital than others. Publicly available data on PHI contracts show that overnight private hospitals represented by groups (whether faith-based or commercial) are most likely to have a full range of contracts with health funds. Faith-based day hospitals and group day hospitals are also well contracted by the health funds.

An exception to this group contracting behaviour is day hospitals specialising in medical oncology and renal care. These are generally group hospitals (for example Icon and GenesisCare for oncology, Fresenius Medical Care and B Braun Avitum for renal care) but are less likely to have a contract with PHIs. PHIs may be torn between the need to provide care to their members, and the high and potentially open-ended outgoings due to the chronic nature of the relevant diseases.

The discrepancy in contracting between day hospitals and overnight hospitals can also be seen in PHDB data. Uncontracted payments to private hospitals in general account for just over 2% of total payments. This figure is 22.0% for the Day Hospital sector. Compared with private overnight hospitals, the proportion of uncontracted health fund payments is more than 20 times higher for day hospitals. In fact, despite day hospitals being only 6% of health fund outgoings, the dollar value of total uncontracted payments is higher for the day hospital sector than it is for the overnight hospital sector. PHIs are leaving cost effective venues of care uncontracted.

¹² Based on data from the PHDB reports from 2012-13 and 2019-20.

There are a number of reasons for leaving certain hospitals uncontracted:

- Contracting with hospitals is time consuming on both sides. At some point the PHIs may decide that the marginal benefit of contracting with another hospital is not worth the effort required in terms of the patient access gained. Particularly when assessing contracting with a small independent hospital, a contract does not facilitate substantial additional access for the PHI's policy holders, by comparison to contracting with a group of hospitals.
- Some insurers ascribe to the theory that by increasing the supply of available contracted operating room time, additional demand for surgical services will be created and outgoings will rise. Alternative viewpoints hold that the volume of procedures in private hospitals, paid for by PHIs, is a function of the number of specialists in private practice, as well as the number of people with hospital cover and with a condition treatable in a private hospital.
- Maintaining uncontracted hospitals on second-tier default benefits arrangements appears cheaper for the PHIs. Given that these payments are 85% of the average of comparable hospitals for a given MBS item, the PHI saves 15% if its policy holder is treated at an uncontracted hospital. This only works to the extent that the admitting doctor is not incentivised to take the patient to a contracted hospital, or the patient does not understand the possible financial implications (i.e. hospital gaps) and the alternatives available to him or her.

Commentary

Despite appearing to be in improving financial shape, PHIs are justifiably concerned about their future.

Community rating makes their product unattractive to attractive customers, despite community rating being one of the best features of private healthcare in Australia.

However, the financial position of private health insurers continues to improve over time, despite structural headwinds. Further, PHIs are failing to contract with and utilise the lowest cost providers in the market. They continue to pay overnight hospitals much more than necessary for the services that their policy holders require.

The financial security of the private health insurers is fundamental to a well-functioning private healthcare market. Four initiatives to provide some relief to the health funds are outlined below.

Proposed initiatives to realise the potential savings

1. Introduce classification system for analysis purposes using MBS Items

Introduction

Procedures carried out in private hospitals are described by Medicare Benefits Schedule item numbers. This schedule forms the basis for funding of doctors and private hospitals. These item numbers are categorised into types “A”, “B”, and “C” within the the *Private Health Insurance (Benefit Requirements) Rules 2011*¹³.

Type A procedures are those which would normally result in an overnight admission. Type B procedures are those which would rarely result in an overnight admission; however, the admitting doctor can certify that this is required. In the same way, Type C procedures are those which would normally not require admission to hospital, but this can be done if the admitting doctor certifies that it is required.

Proposal

We propose a classification system for MBS items which can be provided in standalone day hospitals which are cost efficient centres of care, where there is no medical or geographical reason preventing this to occur. The data resulting from this classification system, will provide evidence of the cost effectiveness of standalone day hospitals. Candidate item numbers and procedures for this categorisation would be those in the calculation in Appendix One – those procedures with very high proportions of same day admissions in overnight hospitals, such as gastrointestinal endoscopy, cataract and other ophthalmic surgery, chemotherapy, oral/dental surgery, haemodialysis, and grommets.

The effect of this would inform doctors, private health insurers and consumers as to the cost effectiveness of day hospitals. There would be exemptions which would include cases where, because of the medical condition of the patient or other special circumstances, admission to a day or short stay hospital would be judged inappropriate by the treating doctor. The savings of this measure as calculated below in Appendix 1 are significant.

2. Encourage PHIs to incentivise use of cost effective venues of care

Two types of incentives are envisaged:

- Incentives to doctors to admit patients to cost effective venues of care
- Incentives to patients to request admission to cost effective venues of care

In general, PHIs appear to favour the “carrot” over the “stick” to influence practitioner and patient behaviour towards cost effective care. However, this can be a troubled area for PHIs to enter. As such it is something that would require cooperation of government and medical peak bodies. The

¹³ <https://www.legislation.gov.au/Details/F2022C00076>

data from the revised classification system will be available through established data sources, such as, PHDB and HCP. This data can be used to refine the classification system.

Incentives to Doctors

Introduction

At present Section 129AA of the Health Insurance Act 1973 appears to prohibit incentives to admit a patient to a particular hospital – however we understand that a private health insurer could not be construed as “a person acting on behalf of ... a proprietor of a private hospital”.

It does not appear to be the intention of this clause to preventing PHIs from encouraging doctors to consider the cost effectiveness of the venue of care appropriate to a particular patient’s needs. Instead, the focus of the clause is on inappropriate inducements.

There are good reasons for implementing such incentives. There are acknowledged potential inconveniences for specialists in choosing to admit a patient to a day hospital:

- it may leave a list incomplete at another facility where the specialist is credentialed
- travel to the day hospital may require additional effort
- admitting a patient for overnight treatment without on-site medical back-up may result in additional requests for advice or assistance from patients or hospital staff

Proposal

Day Hospitals Australia recommends that health funds incentivise doctors to choose a better value venue of care where appropriate. Day Hospitals Australia asserts that medical practitioners will not admit patients with complex needs into hospitals which do not have the capacity to appropriately care for those patients. No incentive will coerce a specialist into admitting a patient to a facility unsuitable to their needs, but such an incentive may give practitioners cause to consider their choices.

The data generated by the revised classification system will provide insurers with significant evidence of the cost benefits to them and their members, in encouraging the use of day hospitals where it is medically appropriate to do so.

Incentives to Patients

There is a broad range of private hospitals in Australia, ranging from single theatre, single specialty day hospitals to private general hospitals with over 500 inpatient beds.

Patients being treated at larger facilities could be perceived as being subsidised by patients who receive the same treatment at smaller facilities, due to the difference in cost between hospitals.

PHIs appear reluctant to offer health insurance policies which offer cheaper premiums in return for a restricted pool of available hospitals for admission. Such a policy would work best in metropolitan areas where patients and their doctors have an abundance of choice, and it may not be offered to prospective policy holders who have less choice in private hospital.

It is also conceivable that exceptions to the restrictions may be made, for example where the patient is admitted to the restricted hospital after genuinely presenting to that hospital’s emergency department.

Another, easier, option for the funds is to reduce or remove excess payments for patients who are admitted to cost effective venues of care. This would still result in an overall cost saving for their private health insurer.

3. Support from Medical Peak Bodies

Introduction

Minimising the need for major reform of the Australian health system is in the interests of all stakeholders, including specialists in private practice. Minimising health insurance premium price rises will also maximise the number of potential private patients. Medical peak bodies – colleges, societies and associations - play a significant role in shaping opinions and the discussion in their field.

Proposal

Day Hospitals Australia suggests that relevant medical peak bodies should advocate to their members for increased use of cost effective venues of care.

This may require some high-level explanation of private hospital funding, particularly that larger private hospitals receive higher reimbursements for the same procedure – and that this price difference is paid for by taxpayers and the privately insured.

4. Cooperatively working to increase the scope of day hospitals

Introduction

Practice in comparable countries (particularly USA and the UK) is towards shorter length of stay for some procedures. This practice is supported for suitable patients by a growing body of peer-reviewed evidence. Reducing the length of stay of patients in a 24 hour facility is good practice but does not attract the cost savings achieved for the same procedure in a free standing day hospital.

Day Hospitals Australia does not support reduction in length of stay to same-day admission and discharge as a goal in itself, but rather as a by-product of evidence-based improvements in practice which make day stay or short-stay surgery feasible for a defined subset of patients. Nor do we support practitioners being pressured to undertake or not undertake a given model of care. This must remain within the professional choice of the practitioners involved. For those practitioners who see merit in shorter length of stay, and enhanced recovery after surgery, these models of care often include:

- modifications in surgical technique or approach
- modifications to anaesthesia and post operative pain protocols
- more intensive attention to the patient from allied health professionals both pre- and post-operatively.

For example, procedures such as joint replacement appear to be better suited to small overnight hospitals – those with a small number of beds for overnight care. While a great deal of THA and TKA

is done same-day in the US, Goyal (2016) recommended that beds be available for the proportion of patients that were planned to be same-day but remained overnight¹⁴.

Proposal

Day Hospitals Australia aims to further engage with Medical Peak Bodies and individual practitioners to encourage discussion and possible adoption of these models of care for suitable patients, together with a shift of these patients to cost effective venues of care to reduce industry costs.

Day Hospitals Australia also suggests that relevant medical peak bodies should advocate to their members to work with smaller hospitals to expand those hospitals' medical scope. The effect of this is to increase the volume of patients that can be safely treated in a cost effective venue of care.

¹⁴ Goyal, N, 2016, A Multicenter, Randomized Study of Outpatient versus Inpatient Total Hip Arthroplasty, Clin Orthop Relat Res (2017) 475:364–372

Conclusions

Need for change

All industry stakeholders understand that the private health sector is not on a sustainable trajectory. At some point in the future, this trajectory could lead to a future government imposing price controls, or perhaps in an extreme case, transitioning to a single-payer or Bismarck-type system. Such reforms may impact stakeholder incomes or viability.

Responsibility

It is incumbent on all industry stakeholders to advocate for a health care system that is cost effective, of high quality and fit for purpose. The Australian health care system is dependent on a viable well-functioning private and public sector. Zero-sum game approaches must be set aside to preserve both the private and the public components of our health care system.

Contribution

Day Hospitals represent approximately 6% of the private health insurance industry's outgoings to private hospitals. Private Health Insurers' outgoings to private day hospitals total approximately \$620M¹⁵. In this document, we propose savings to the industry of potentially \$508M. This is proportionally a substantial contribution to the viability of the Australian private healthcare system.

Activities

Day Hospitals Australia would like to engage with your professional society to discuss this report and these proposals in more detail to better understand the medical perspective and develop innovative models of care. From this we may cooperatively decide which measures can be implemented, and what Day Hospitals Australia can do to help realise these cost savings.

Professional Freedom

Day Hospitals Australia has no interest in restricting the professional freedom of practitioners. Many of our member hospitals are owned either partially or fully by the doctors who practice within them. Our experience is that practitioners put patient wellbeing and outcomes ahead of all else, and nothing in this document seeks to change that.

Appendix One – Cost Savings Calculation

Transition of same-day procedures from overnight to day hospitals

Data Source

The latest available PHDB report at the time of writing was used as the primary data source. This was the 2019-2020 edition. The PHDB data is categorised by venue of care – day hospitals and “other” – i.e. overnight, palliative care, mental health, rehabilitation. For the initial analysis of where the savings opportunities lie, the day hospital data was filtered out.

PHDB data is also categorised by AR-DRG code (Australian Refined Diagnosis Related Groups) which groups activities with related diagnosis and intervention codes together. Version 10 of AR-DRG was used, focusing on procedures with a very high proportion of same-day separations being performed in overnight hospitals.

This data was somewhat affected by the coronavirus pandemic. PHDB data shows a 6.6% reduction in the number of separations from private overnight facilities nationally compared with the previous 12-month period. This was principally due to the national elective surgery restrictions which ran from 27 March 2020 and gradually reduced from 27 April 2020. PHDB data includes some publicly funded patients treated in private hospitals, noting that privately operated hospitals treating predominantly publicly funded patients are removed from the data.

Method

DRG codes with no data were removed from the list: this included care for neonates, tuberculosis, specialised nervous system disorder codes, artificial heart implantation, pyloromyotomy, kidney transplant, bone marrow transplants, procedures following multiple significant trauma, burns treatments (incl skin grafts), and effects of drugs requiring ventilator support.

The remaining data was ordered by proportion of same day separations, which ran from 100.0% (5 DRG items, 474,000 separations) through to 0.0% (102 DRG items, 83,000 separations)

A number of other DRG codes were removed as being unlikely in the day hospital context:

- Neurology codes: B68B, B71B, B67C
- Codes Q60B (reticuloendothelial etc)
- Cardiology: F68Z
- I66B – inflammatory musculoskeletal disorders – arthritis, etc
- Mental health removed (U40Z, U60Z) – day hospitals carry out 2.2% of same-day mental health treatments – and none of U40Z. We do not propose that same day mental health treatments should be removed from specialised mental health facilities – overnight or same day.

The following DRGs have also been removed, although there is a case to retain them.

- Z64B – 56,000 seps, with a wide variety of Principal Diagnoses
- G64Z - 21,488 seps

The proportion of same day separations is given in the data. DRG codes with this proportion under 90% have been removed. These remaining DRG codes represent a set of procedures after which the clinician would normally discharge the patient from hospital on the day of treatment. Reasons for keeping the patient overnight can be divided into three groups:

- patient factors (co-morbidities, social support)
- the specific procedure being carried out (i.e. DRG code includes some diagnoses/procedures which would normally require an overnight stay)
- variations in clinical practice or judgement

In total 65.4% of separations from private overnight hospitals were reported as being same day. It is acknowledged that this includes data from mental health and rehabilitation hospitals which have same-day treatment programs alongside overnight patients.

Calculation

There are approximately 3.5 million separations annually from Australian Private overnight hospitals¹⁵. Of these, approximately 2.8 million separations were privately funded, and 1.8 million of those separations were same day¹⁶.

Analysis focused on those AR-DRG codes with a proportion of same-day discharge higher than 90%. This suggests that the procedure, or group of procedures within the AR-DRG code, is generally possible to carry out in the DH environment. This resulted in a list of 41 AR-DRG codes. Nine of these codes were judged unlikely to be undertaken in a typical day hospital, as the relevant specialties are not generally present in Day Hospitals. These specialties are:

- Psychiatry (same day mental health treatments)
- Neurology
- Haematology (oncology is included under chemotherapy R63Z)
- Cardiology

This leaves 32 AR-DRG codes, together responsible for just over a million same day separations from overnight hospitals in the 2019-20 financial year. The 32 DRG codes with same-day proportions higher than 90% include 1.07 million same-day separations, and 34,000 overnight separations. The total hospital charge (no medical component) for these same-day separations was calculated for both day hospitals and overnight hospitals, based on the “Average hospital charge per separation” which is listed per DRG code in the PHDB report. In other words, the actual cost to PHIs of same-day separations in overnight hospitals can be compared to what these same separations would have cost the PHIs had they taken place in day hospitals.

Results

These episodes of care would have realised a saving of \$343 million had they been undertaken in day hospitals, or a saving of 30%. Not all of this amount is available to PHIs. The PHDB data from 2019-20 includes \$13.6B in private hospital charges. Almost \$11B of the \$13.6B (or 80.7%) is paid for by private health insurers (see [Figure 6](#)). This means that the \$343M total ought to be reduced to \$277M. The remaining \$66M savings is available to other payers of private healthcare. Dividing

¹⁵ Private Hospital Data Bureau, Department of Health, 2021, The PHDB Annual Report 2019-20

¹⁶ Department of Health, 2021, *Hospital Casemix Protocol Annual Report 2019-20*, Table 4

this \$277M by the 5.66M hospital cover health insurance policies as at September 2021¹⁷, means that better use of day hospitals could deliver an annual saving of up to \$50 per policy. Adding in the savings from joint replacements and lower inpatient rehab lifts this per-policy saving to \$72 per year.

Sources of Funding - Private Hospitals

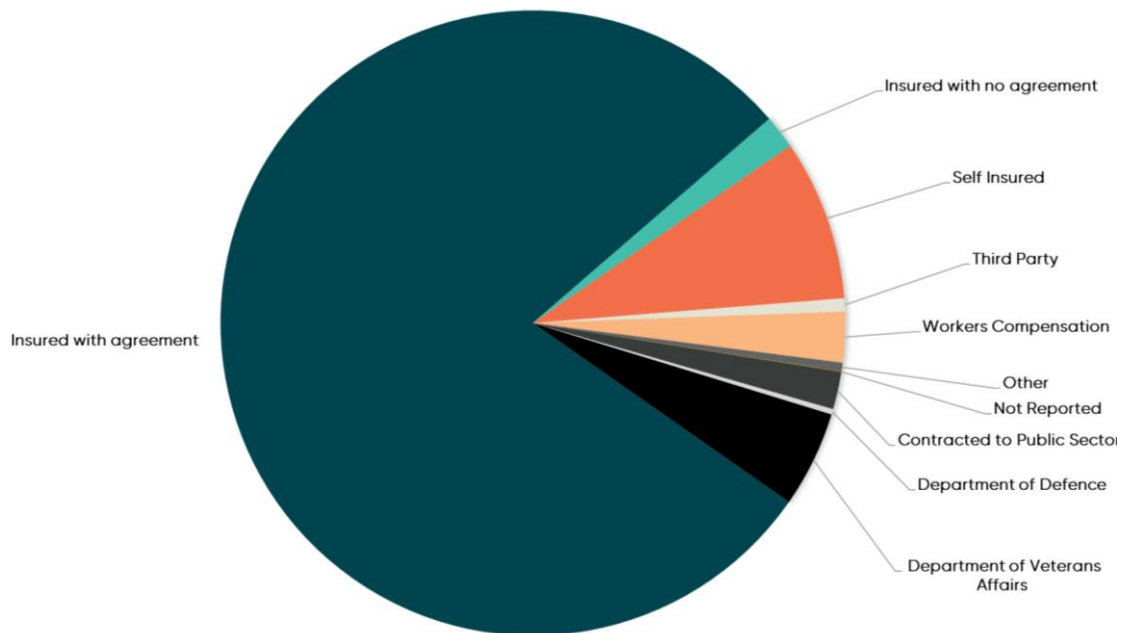


Figure 6: Sources of Private Hospital Funding (PHDB 2019-20)

Chemotherapy, GI endoscopy, and ophthalmology alone contribute 60% of this value.

The same calculation can be carried out using Hospital Casemix Protocol (HCP) data. This results in 29 DRG codes with same day separation proportions above 90%. The difference calculated using this data is \$265M, or 31%. This corresponds quite well with the calculation made using PHDB data.

¹⁷ Australian Prudential Regulation Authority, 2021, Private health insurance membership trends

Appendix Two

List of AR-DRG codes from PHDB data with at least 90% same day separations in overnight facilities:

Note that items in yellow are not included in the calculations.

AR-DRG code	AR-DRG description	Separations (from ON)	Average length of stay	Same-day separations (from ON)	% Same Day
U60Z	Mental Health Treatment W/O ECT, Sameday	203545	1	203545	100.0%
U40Z	Mental Health Treatment W ECT, Sameday	10093	1	10093	100.0%
M40Z	Cystourethroscopy for Male Reproductive System Disorder, Sameday	8468	1	8468	100.0%
B40Z	Plasmapheresis W Neurological Disease, Sameday	170	1	170	100.0%
R63Z	Chemotherapy	251533	1	251500	100.0%
M63Z	Male Sterilisation Interventions	4791	1	4752	99.2%
D13Z	Myringotomy W Tube Insertion	10236	1	10129	99.0%
N11B	Other Female Reproductive System GIs, Minor Complexity	5300	1	5239	98.8%
D40Z	Dental Extractions and Restorations	61232	1	60294	98.5%
L61Z	Haemodialysis	125991	1	124034	98.4%
Z64B	Other Factors Influencing Health Status, Minor Complexity	56335	1.1	54917	97.5%
Z40Z	Other Contacts W Health Services W Endoscopy	75498	1	73503	97.4%
G64Z	Inflammatory Bowel Disease	21488	1.1	20916	97.3%
N10Z	Diagnostic Curettage and Diagnostic Hysteroscopy	19055	1	18511	97.1%
C16Z	Lens Interventions	73135	1	70773	96.8%
C14B	Other Eye Interventions, Minor Complexity	1129	1	1092	96.7%
C12B	Other Corneal, Scleral and Conjunctival Interventions, Minor Complexity	2809	1	2714	96.6%
C13Z	Lacrimal Interventions	292	1	282	96.6%
G47C	Gastrosocopy, Minor Complexity	63761	1.1	61360	96.2%
G48B	Colonoscopy, Minor Complexity	142737	1	137164	96.1%
B68B	Multiple Sclerosis and Cerebellar Ataxia, Minor Complexity	7245	1.2	6906	95.3%
M05Z	Circumcision	4201	1	4004	95.3%
C03B	Retinal Interventions, Minor Complexity	17132	1	16304	95.2%
B05Z	Carpal Tunnel Release	15366	1	14594	95.0%
G46B	Complex Endoscopy, Minor Complexity	97374	1.1	92411	94.9%
N07B	Other Uterus and Adnexa Interventions for Non-Malignancy, Minor Complexity	29286	1	27770	94.8%
Q60B	Reticuloendothelial and Immunity Disorders, Minor Complexity	12437	1.1	11778	94.7%
N09B	Other Vagina, Cervix and Vulva Interventions, Minor Complexity	12254	1	11572	94.4%
K40B	Endoscopic and Investigative Interventions for Metabolic Disorders, Minor Comp	15003	1.1	14079	93.8%
L44B	Cystourethroscopy for Urinary Disorder, Minor Complexity	27833	1	26080	93.7%
O05Z	Abortion W GIs	7531	1	7041	93.5%
J11B	Other Skin, Subcutaneous Tissue and Breast Interventions, Minor Complexity	27279	1	25416	93.2%
B71B	Cranial and Peripheral Nerve Disorders, Minor Complexity	13472	1.2	12536	93.1%
C14A	Other Eye Interventions, Major Complexity	39	1	36	92.3%

C15B	Glaucoma and Complex Cataract Interventions, Minor Complexity	4952	1	4567	92.2%
F68Z	Congenital Heart Disease	451	1.4	411	91.1%
B67C	Degenerative Nervous System Disorders, Minor Complexity	5464	1.4	4973	91.0%
M60B	Male Reproductive System Malignancy, Minor Complexity	14008	1.2	12683	90.5%
I66B	Inflammatory Musculoskeletal Disorders, Minor Complexity	9398	1.5	8504	90.5%
C10Z	Strabismus Interventions	1144	1	1029	89.9%
Q61C	Red Blood Cell Disorders, Minor Complexity	17951	1.1	16121	89.8%

Table 5: List of relevant AR-DRG codes