Day Hospitals
AUSTRALIA

PRIVATE HEALTHCARE'S FORK IN THE ROAD

SUMMARY

The Private Healthcare Sector is in a worsening state. Private Health Insurers have an aging demographic and increasing benefits outlay to manage, while Private Hospital operators of all sizes are battling declining or negative net profit margins. Day Hospitals remain the answer for the Private Healthcare Sector. However, the tendency towards increased use of higher cost, inpatient private hospitals for simple day procedures demonstrates the sector is drifting towards extinction.

Day Hospitals Australia Ltd

Executive Summary

In 2022, Day Hospitals Australia released a report demonstrating that there are large savings available to the private health sector. These savings can be readily realised if private health policy settings were in place to ensure that day hospitals or smaller lower cost private hospitals were used for simple hospital treatments where appropriate to each patient's needs and condition.

This new report builds on the calculations in that paper and looks at what has happened over the past decade with payments from private health insurers to private hospitals for treatments provided to private health insurance policy holders.

In many cases, the price gap between overnight hospitals and day hospitals for a given treatment is increasing – in other words, not only do private health insurers pay overnight hospitals more than day hospitals, but the prices paid to overnight hospitals have increased at a higher rate than the prices paid to day hospitals.

This demonstrates the market power of the larger private hospital groups relative to private health insurers and the comparative lack of market power of mostly independent day hospitals when negotiating with private health insurance organisations that are significantly larger enterprises.

Some treatments are eminently suited to the day hospital environment. This is something on which the entire sector can agree, as two thirds of admissions to overnight hospitals are same-day episodes, and this proportion is increasing over time.

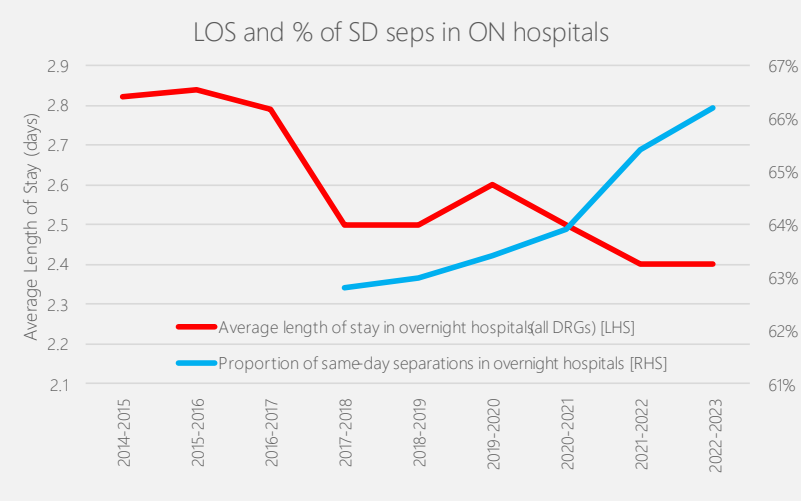


Figure 1: Trend of LOS and % same day in overnight hospitals

The consequences of this will be disastrous for private health insurers. The lowest cost providers of treatments are being pushed out of the market and into administration or bankruptcy.

This means that, not only will the industry forgo the available savings, but the payers will be forced to pay the higher cost of their members' hospital care to be provided in overnight hospitals.

- Scenario One – the volume split between day hospitals and overnight hospitals remains as it was in 2023.
- Scenario Two – day hospitals are forced out of business by low benefits, sending their volume to overnight hospitals.
- Scenario Three – the volume in overnight hospitals transfers entirely to day hospitals.

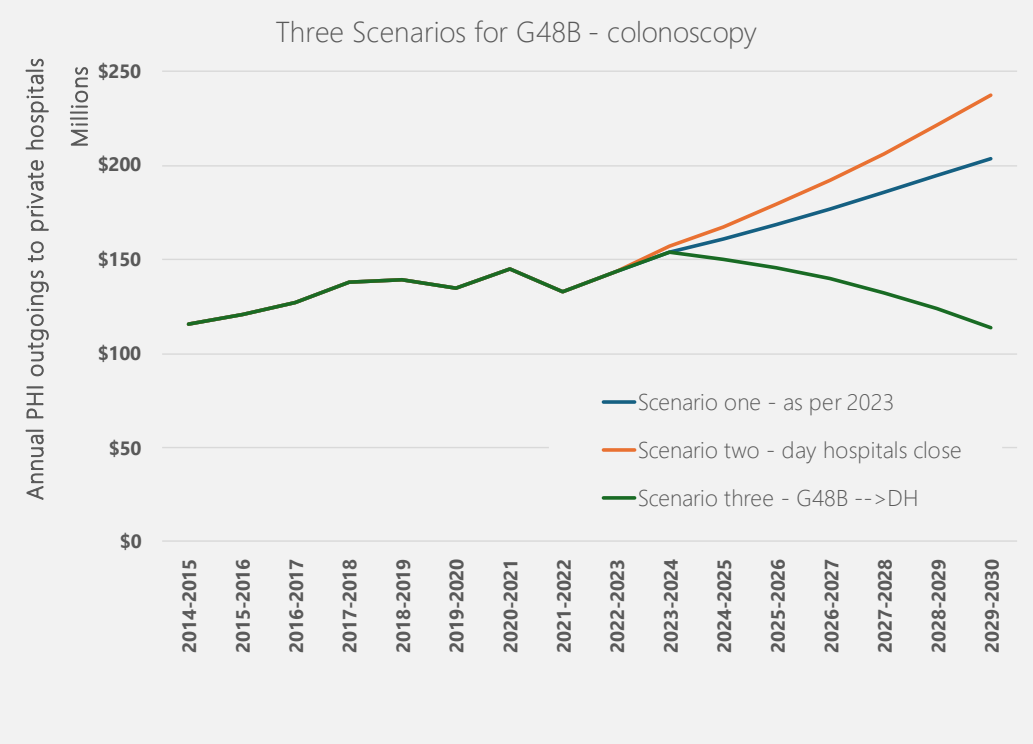


Figure 2: Future scenarios for G48B colonoscopy.

Figure 2 is the visual representation of the fork in the road for private healthcare. Note that these three scenarios include growth in the volume of colonoscopies, and the same average annual benefit indexation as experienced over the past decade for the two categories of private hospitals. Two of these scenarios are extreme outcomes, but they are a guide to the range of possibilities available to private healthcare within this single DRG.

It is imperative for the affordability of private healthcare and private health insurance premiums, that more day procedures are directed to day hospitals, and that day hospitals are remunerated at a level sufficient to ensure their viability.

The remainder of this report is divided into three sections:

Contents

1. Procedure Cost

1.1. Introduction

Various hospitals are paid widely different amounts for providing the staff, venue and equipment for a given procedure. In general, larger hospitals are paid more, while smaller hospitals and day hospitals are paid less for the same procedure.

This is for three principal reasons:

- Larger hospitals and large hospital groups have historical prices which have indexed over a long period of time and are hard for private health insurers to "reset" to reasonable levels.
- Day hospitals offered themselves at a price advantage when the first stand-alone facilities were developed in Australia three decades ago.
- Larger hospitals and large hospital groups, have significant market power in discussions with the private health insurers[1,2]

This price differential means that private hospital insurers are paying far more for many procedures than necessary. Admission to expensive hospitals is appropriate for private health insurance policy holders who, due to their condition, need the critical care and other services that some larger hospitals provide, however for many procedures the proportion of patients in this category is vanishingly small.

Policy holders that are admitted to a lower cost facility are subsidising the healthcare of their fellow policy holders who are admitted to a higher cost facility. Cross-subsidisation of high-complexity admissions through overpaying overnight hospitals for same-day procedures introduces distorted incentives to the private healthcare sector.

1.2. Data sources

This report relies on publicly available data – specifically the Hospital Case mix Protocol (HCP) Annual Reports published by the Commonwealth Department of Health and Aged Care. As the format and input data for these reports' changes over time, the report from the 2014-15 financial year is the earliest report that is directly comparable with the latest report (from the 2022-23 financial year).

[1] Ramsay terminates with Bupa - https://www.afr.com/companies/healthcare-and-fitness/ramsay-confirms-its-contract-with-bupa-is-void-20220802-p5b6hl

[2] Healthscope terminates with HCF - https://www.smh.com.au/national/nsw/hcf-patients-to-lose-cover-at-major-sydney-hospitals-20221202-p5c33h.html

Private hospitals are required to supply the source data for the HCP reports to health insurers – each episode of care produces a file segment which must be sent to the relevant private health insurer. Within this episode file segment are the amounts which were charged by the hospital to the patient and / or the patient's private health insurer. In the same way, using the "HCP1" data specifications, private health insurers are required to add to this HCP data, and forward it to the Department of Health and Aged Care for processing into the HCP annual reports (as well as for other uses by the department).

This is required by the Private Health Insurance Act 2007 (Cth), section 121-5 (7) (e) – which in turn points to the Private Health Insurance (Health Insurance Business) Rules, and section 157-5, which refer to the Private Health Insurance (Data Provision) Rules.

In particular, the private health insurers are required to add what amounts were paid to the hospital and/or the patient for this episode of care ("benefits"). These benefits indicate the average contract prices that hospitals are paid by private health insurers for procedures. The value of excesses and co-payments ("front end deductibles" in the HCP specifications) are collected but not reported, for the purpose of this report these are assumed to be constant over time, and to not impact the validity of the conclusions drawn below.

1.3. Selection of Procedures for Analysis

The data in HCP Annual Reports is broadly separated by DRG, state, hospital type (day hospital or "other"- i.e. overnight hospital, mental health hospital, or rehabilitation hospital).

The most recent HCP Annual report includes 783 DRGs. In some cases, there is a good match between a specific DRG, and a procedure or a small group of procedures. High volume examples of this are gastrointestinal endoscopy (G46, G47, & G48), chemotherapy (R63Z), and haemodialysis (L61Z). The following ten DRGs have been selected for comparison between day hospitals and overnight hospitals.

B05Z – Carpal Tunnel Release
C16Z – Ophthalmology - Lens procedures
D40Z – Dental extractions and restorations
G46B – Complex endoscopy, minor complexity
G47C – Gastroscopy, minor complexity
G48B – Colonoscopy, minor complexity
L44B – Cystourethroscopy for urinary disorder, minor complexity
L61Z – Haemodialysis
N10Z – Diagnostic curettage and diagnostic hysteroscopy
R63Z – Chemotherapy

The common characteristics of these ten DRGs are:

- They are high volume (and so have material impact on private health insurers outgoings)

- They have a very high proportion of same-day admissions in overnight hospitals (>95%)
- The DRG represents a small range of procedures (so that there is no significant case mix difference between hospitals)

Five of these DRGs are outlined in more detail here within three specialty areas. The remaining five DRGs are outlined further in Appendix One.

1.4. Procedures

1.4.1. Gastrointestinal Endoscopy

Endoscopists are either general surgeons or gastroenterologists, with their training recognised by the Conjoint Committee within the Gastroenterological Society of Australia. Common procedures are gastroscopy, colonoscopy and combined gastroscopy and colonoscopy. These procedures are categorised under the DRGs G46, G47 and G48, and to a lesser extent DRG Z40Z.

This group of procedures is among the most common, due to low cost and high diagnostic and treatment power, and programs such as the National Bowel Cancer Screening Program. As a result, the private health insurance sector pays nearly $1b in benefits annually for these procedures.

Overnight hospitals are paid substantially more for this group of procedures than day hospitals and yet over 70% of endoscopy patients are admitted to overnight hospitals for predominantly same-day episodes. If the minor complexity episodes currently done in overnight hospitals were instead done in day hospitals, the private health insurers would save a collective $133m annually.

The volume of GI endoscopy procedures carried out in day hospitals has declined by 8% since 2014-15, while these procedures carried out in overnight hospitals have increased by 21% over the same period.

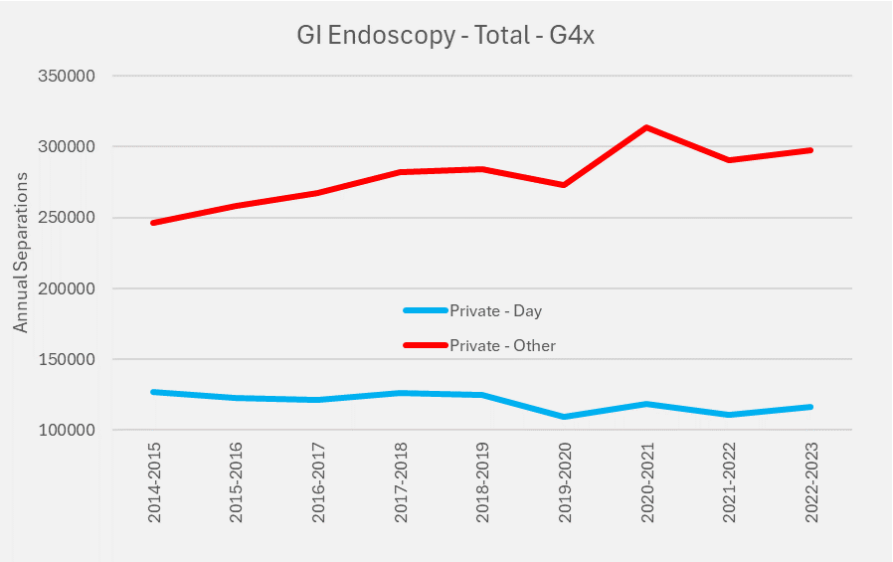


Figure 3: Patient volume for endoscopy day hospitals and overnight hospitals

In addition, the prices paid by private health insurers to day hospitals has increased by 8% over this timeframe, while prices paid to overnight hospitals increased by 23%. At the start of the time period shown, private health insurers paid overnight hospitals 70% more than they pay day hospitals for a minor complexity colonoscopy. Now, private health insurers pay overnight hospitals 90% more than day hospital for a minor complexity colonoscopy. This large overpayment for a common procedure to overnight hospitals – and the simultaneous constraint of payments to day hospitals for the same procedure – has a significant impact on the cost of private healthcare.

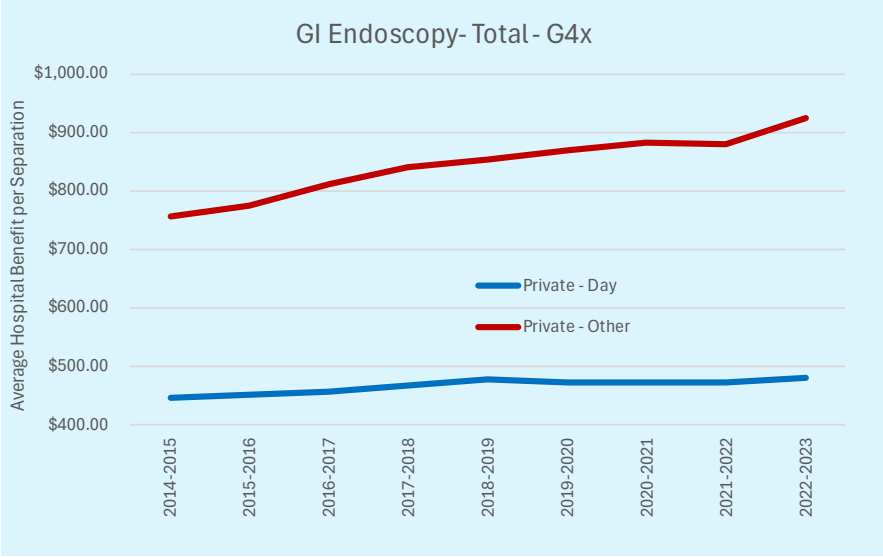


Figure 4: Difference in benefits for endoscopy procedures: day hospitals and overnight hospitals

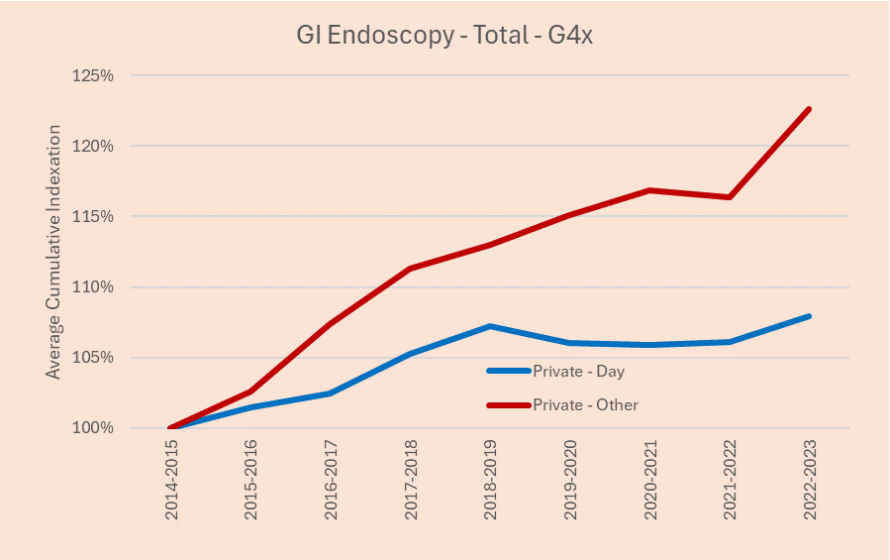


Figure 5: Cumulative benefit increase: day hospitals and overnight hospitals

The cumulative effect of this is to render GI endoscopy financially non-viable for day hospitals. Melbourne Endoscopy Group has recently ceased trading at its three facilities, and it is unlikely to be the last endoscopy-focused operation to close. If GI endoscopy is moved completely to overnight hospitals, the health funds will be required to pay an additional $70m annually for these procedures.

The gap between acting to maintain day hospitals in the GI endoscopy business, and not acting is therefore $200m annually.

1.4.2.Chemotherapy

Chemotherapy, like haemodialysis, is a rather low paid procedure by comparison to most other hospital interventions. However, the high number of separations, caused by the chronic nature of the diseases, and the need for regular treatments, means that haematology and oncology result in large outgoings for the private health insurers.

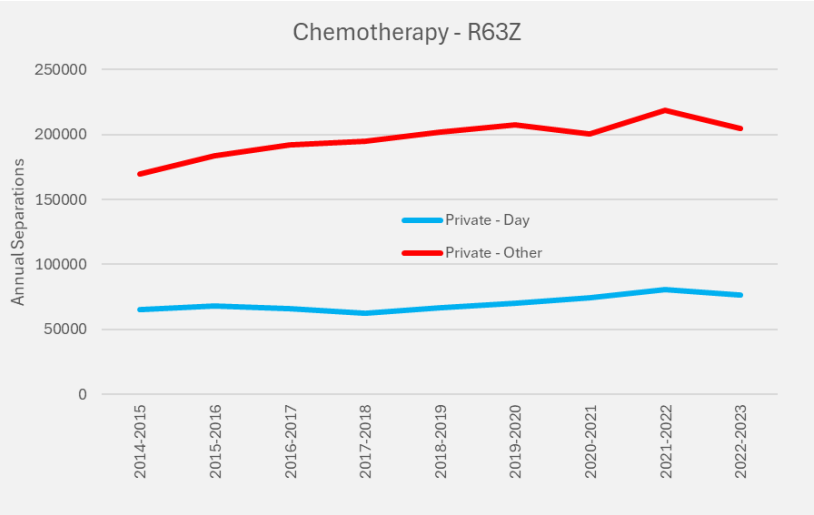


Figure 6: Volume of Chemotherapy treatments: day hospitals and overnight hospitals

The volume of patients treated with chemotherapy in day hospitals has grown only slightly and slower than in overnight hospitals. Both hospital categories report 100% of patients being discharged on the day of treatment.

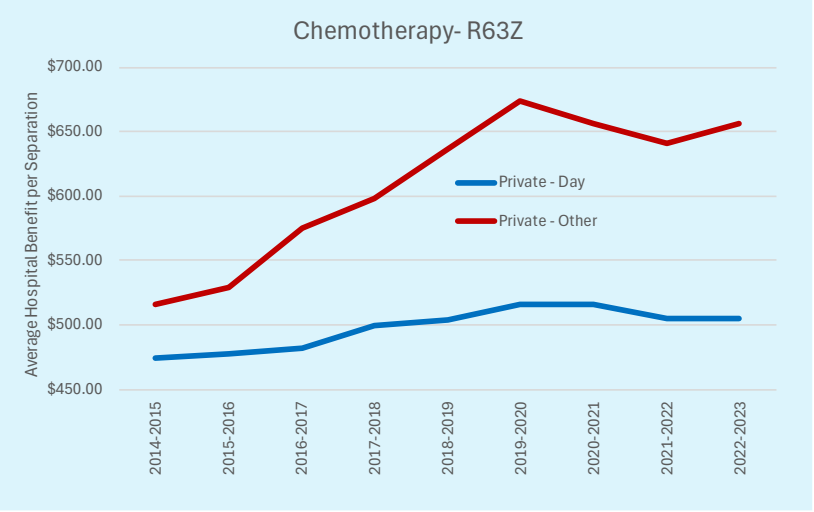


Figure 7: The difference in benefits paid: overnight hospitals and day hospitals

However, the price paid to overnight hospitals for chemotherapy treatment has increased substantially faster than the price paid to day hospitals. The reimbursement for chemotherapy treatment at day hospitals has increased by 6% since 2014, while the reimbursement to overnight hospitals for the same period and treatments has increased by 27%. It is worth noting that most day hospitals in this space are completely focused on oncology, with the quality and patient experience benefits that such focus brings. There was a 'bounce' in patient volume in the 2021-22 financial year as a result of fewer patients presenting in 2020-21 due to restricted movement during the pandemic.

Private health insurers currently spend $236m per annum for chemotherapy treatments; provided to their members, for this, $173m goes to private hospitals of both categories. If patients that are currently directed to overnight hospitals were instead admitted to day hospitals (or alternatively if overnight hospitals were paid at the same rates as day hospitals), the private health insurance sector would save approximately $31m annually. If chemotherapy is moved completely to overnight hospitals, the health funds will be required to pay an additional $12m annually for these procedures. The gap between acting to maintain day hospitals in the chemotherapy business, and not acting, is therefore $43m annually.

1.4.3.Ophthalmology

Ophthalmology as a whole, and lens procedures (DRG C16Z) in particular, is an unusual case for two reasons:

a) More patients are admitted to day hospitals for ophthalmic procedures than overnight hospitals. Two-thirds of ophthalmology patients are admitted to day hospitals.
b) The price gap between day hospitals and overnight hospitals is narrowing over time, particularly caused by a decline in average prices paid to overnight hospitals at the end of the last decade.

For lens procedures in particular, volume growth has been predominantly in day hospitals (30% in day hospitals against 8% in overnight hospitals), while the prices have risen together, despite overnight hospitals being paid 15% more for the same procedure.

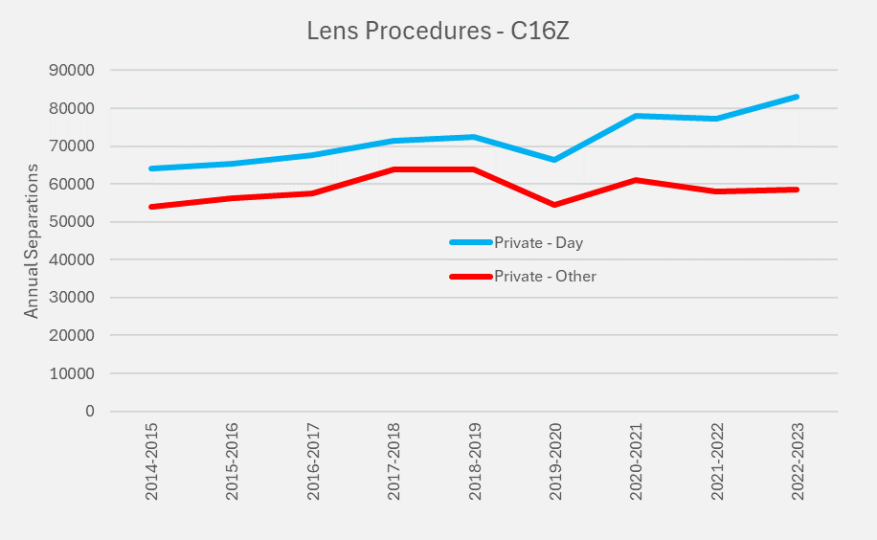


Figure 8: Patient volume for lens procedures (cataract): day hospitals and overnight hospitals

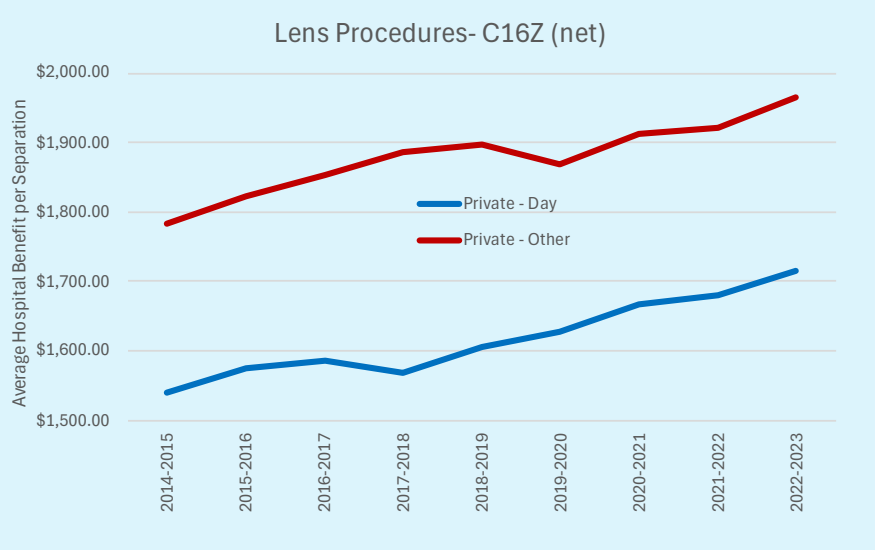


Figure 9: Difference in benefits for lens procedures: day hospitals and overnight hospitals (net of prostheses)

It is also interesting to note that the ophthalmology case mix across the specialty differs between overnight hospitals and day hospitals. Over three-quarters of overnight hospitals ophthalmology interventions are for cataract – the corresponding figure for day hospitals is just over half. For day hospitals, 40% of their case mix is (lower-paid) retinal procedures, while 13% of overnight hospitals ophthalmology interventions are retinal procedures

In FY23, 3788 patients had an overnight stay following admission for ophthalmology interventions in overnight hospitals, this is approximately 4% of the total, while the equivalent rate for day hospitals is 0.1%. To the extent that overnight hospitals are paid a higher rate for an overnight stay, this increases the average benefit paid by the private health insurer.

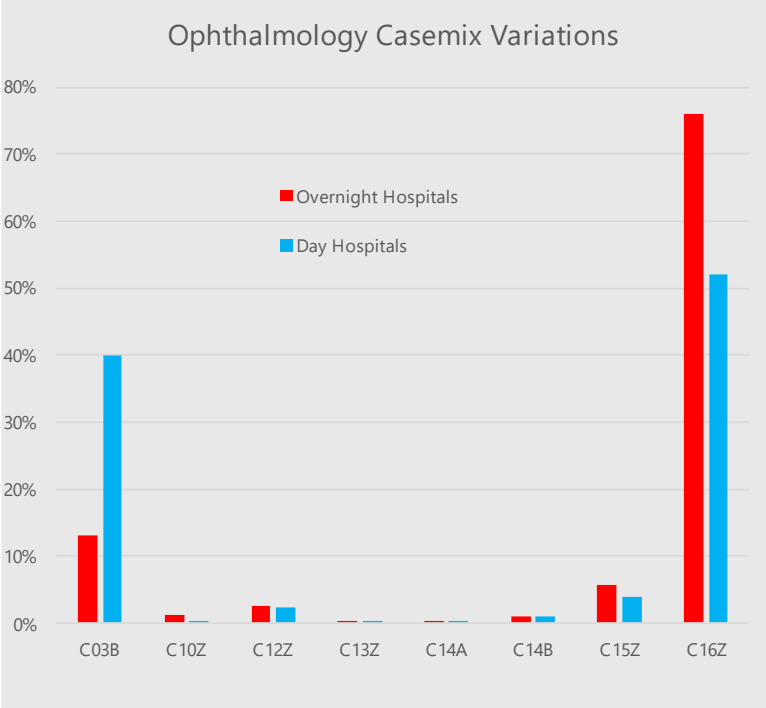


Figure 10: Case mix variations – overnight hospitals and day hospitals

Ophthalmology is another specialty with large outgoings for private health insurers – over $800m per annum. Looking only at same-day separations for interventions, if the patients currently admitted to overnight hospitals were admitted instead to day hospitals, the private health insurers would save approximately $30m. If day hospitals closed, the additional cost of accommodating patients that currently are admitted to day hospitals would be over $70m annually.

The fork in the road for the private healthcare sector has a current value of $100m in ophthalmology

1.5. Summary

The Day Hospital sector is at a fork in the road. As reported by large private hospital companies[3,4], it appears that all private hospitals are under financial pressure at present. The issue for these large companies is reported as being large debt load or poor investment choices.

The key challenge facing day hospitals is being expected provide the same services, to the same standards[5], with the same staff, but for a fraction of the remuneration. Day Hospitals are no longer the feasible businesses they once were, and more low-paid hospitals will be closed, leaving

[3] Simon Evans, Australian Financial Review, Feb 29, 2024, *Ramsay Health Care warns of hospital closures as costs blow out*
[4] Sarah Thompson, Australian Financial Review, March 26, 2024, *Healthscope lenders poised to appoint Houlihan Lokey amid restructure*
[5] https://www.safetyandquality.gov.au/standards/nsqhs-standards

the well-paid hospitals as the only suppliers to the private health insurance sector. Payers are overpaying some overnight hospitals (and likely a very small number of day hospitals) and are thereby missing out on large savings.

The impact of the private healthcare sector running day hospitals out of business is summarised in the table below – noting that this represents 10 DRGs out of a total of 783.

DRG	Description	Impact (annual)
B05Z	Carpal Tunnel Release	$5m
C16Z	Lens Interventions	$100m
D40Z	Dental Extractions and Restorations	$20m
G46B	Complex Endoscopy, Minor Complexity	
G47C	Gastroscopy, Minor Complexity	$200m
G48B	Colonoscopy, Minor Complexity	
L44B	Cystourethroscopy for Urinary Disorder, Minor Complexity	$10m
L61Z	Haemodialysis	$23m
N10Z	Diagnostic Curettage and Diagnostic Hysteroscopy	$12m
R63Z	Chemotherapy	$43m
Total		**$413m**

2. Causes and Potential Solutions

2.1. Causes

Four causes have been identified which contribute to excess costs of private healthcare. There may be further issues driving low value for the payers, but these are not tackled here.

2.1.1. Market structure

Some aspects of the private healthcare market are subject to the normal forces of a competitive market, such as selling health insurance policies to consumers. Other things being equal, a higher premium for a given level of cover results in lower share of market. This is, in part, because the purchaser of the policy is also the payer and the beneficiary.

Many other aspects of private healthcare are not subject to these forces. The choice of venue of care is one of these. While smaller, lower cost venues of care are clinically equivalent to larger, more expensive venues, this difference in cost is not seen or felt by the person choosing the venue or the person being treated in the venue - the admitting specialist and the patient, respectively.

2.1.2. Choice of venue of care

There are a range of factors that admitting specialists consider when choosing where to admit and treat their patients.

Some patients may require an overnight stay post-surgery, although average lengths of stay are reducing, and many common procedures, such as joint replacements, are done as same day procedures in other parts of the world. Individuals at greater risk of poor health outcomes due to comorbidities may require the support that can be offered at a larger hospital.

For the vast majority of patients in the treatments discussed in section 1.4 above, the data indicates that patient characteristics are not determinants in the choice of venue of care, and that these choices are based on non-clinical factors.

These are:

- The requirement to maintain and fill a regular list at an overnight hospital in order to have access to overnight beds and medical back-up for those patients that do need such care.
- Underutilising a list at an overnight hospital may lead to loss of admitting rights at that hospital in favour of another specialist who will fill the list.
- The convenience of undertaking procedures near (perhaps in the same building) as the specialist's rooms.
- The convenience of undertaking all procedures at the same place (whereas streaming patients into different venues of care on the basis of clinical need whilst perhaps less convenient – would result in a lower cost outcome).

As outlined in section 1.5 above, these factors carry a significant cost penalty for the payers in the private healthcare sector (and so ultimately consumers and taxpayers). There is also an element of the *Tragedy of the Commons* in that the benefits of admitting a patient to an expensive overnight hospital are felt by the specialist, while the costs are borne by insurers and ultimately the community.

2.1.3.Incentives for overnight hospitals

The perpetuating current paradigm where large players with overnight hospitals are paid significantly more for these simple services is an incentive for those operators to do more of these more profitable (to them) procedures that should instead be done by lower cost providers. While these procedures can be marginally profitable for efficiently run and relatively well-paid day hospitals, they are a source of significant profit for overnight hospitals.

This profit is a strong incentive for overnight hospitals to do whatever they can to incentivise admitting specialists to undertake more of these day procedures in their hospitals. This strategy is working, as is seen in the data in section 1.4. to the cost for the private health insurers.

One anecdotal argument used by operators of large hospitals is that the excess margin on (for example) colonoscopy helps to fund lower margin procedures within the same hospital or group. This cross-subsidisation is more likely to result in oversupply of higher margin procedures, and undersupply of low margin procedures, to the detriment of patients. Patients, and their doctors, are best served when the hospital is indifferent as to what procedures are undertaken within their facilities. This is at present not the case, as certain specialties are finding it increasingly difficult to retain lists at overnight hospitals, because their procedures are less profitable than some others. Conversely, the competition for hospitals to host lists in certain highly profitable specialties has never been higher.

2.1.4.Market power

Private health insurers, whilst complicit are not *willingly* paying more to the large overnight hospitals for procedures which could be more efficiently undertaken in specialised day hospitals. This demonstrates a lack of their market power by comparison to their largest suppliers. These major suppliers are:

Group	Estimated annual revenue
Ramsay Healthcare	(Asia Pacific) $5.7b
Healthscope	$2.8b
Catholic Negotiating Alliance	$4.3b

The private health insurers lack of market power renders them unable to make structural changes, for example to reset the variations in gross margin by procedure or specialty.

2.2. Solutions

2.2.1. Background

Admitting specialists are in the best position to influence the choice of venue of care, and to select the venue which best suits their patient's needs and makes best use of finite healthcare resources.

A proportion of specialists would take costs and private healthcare feasibility into account when choosing a venue of care, but they are unaware of the cost differentials between the various hospitals at which they are credentialled.

In the absence of private health insurers making it possible for admitting specialists to know these prices, some other form of signal is required.

While the solutions suggested in this are straightforward, implementation is anything but. A number of mechanisms to effect change are suggested below. Any change must take into account the needs of all players in the market, and the transition ought to be slow enough to allow providers and insurers to make adjustments to suit.

While not wanting to entirely conflate "lower cost venues of care" and "day hospitals", this is a natural correlation to draw out and existing regulation identifies day hospitals as a specific category and collects data enabling regulators to make decisions and set policy to ensure the available cost advantages are realised to ensure a sustainable private healthcare system.

Some other hospitals, such as small community hospitals or short-stay hospitals, which have a small number of overnight beds, but which may not enjoy high prices for their services, could be unfairly disadvantaged by a blanket *day hospital – overnight hospital* distinction. Further development of the ideas presented here might lead to another way to characterise hospitals based on their cost-effectiveness.

2.2.2. Incentive

An incentive to admit suitable patients to lower cost venues of care is the preferred option. This may require regulatory intervention so that the private health insurers have a clear mandate and mechanism to participate.

Incentives could be applied to either or both the admitting specialist and the patient. The goal of incentives is to reward the desired behaviour.

These would be preferable over regulation as they would be simpler to introduce and are less at risk of being seen as coercive.

Such incentives could take the form of differentiated Medicare scheduled fees (or percentage rebate applied to scheduled fees), which is then amplified by each insurers' gap cover medical payments, so that there is an appreciable difference in medical fees driving admitting specialists towards lower cost venues of care where appropriate.

The disadvantage of this option is that there is some extra cost paid in the form of incentives for the 666,000 episodes of care which already take place in day hospitals, and there is also incentive for specialists to admit patients to the very small number of well-paid day hospitals.

Another incentive could be directed towards patients, in the form of excess reduction for admission to low-cost venues of care. Again, the disadvantage of this option is that insurers may pay incentives for behaviour that was going to happen anyway.

2.2.3. Regulation

Another option is to use a regulatory mechanism to drive specialists and their appropriate patients to lower cost venues of care. While this would undoubtedly be effective, this is not the preferred option for two reasons:

- Players in the private healthcare sector are more likely to act and react positively to an incentive rather than a regulation, and
- There is an appreciable chance of unintended consequences from introducing any new regulation.

Encouraging more admissions to lower cost venues of care could be achieved by a minor extension of the procedure type system within the *Private Health Insurance (Benefit Requirements) Rules 2011*. Procedures are banded into types A, B and C by MBS item number, in the following way:

Type	Description
Type A	Usually done in hospital, may include overnight stay
Type B	Usually done in hospital, usually without overnight stay
Type C	Doesn't normally result in admission to hospital

Variations from these requirements are allowed if the admitting specialist certifies in writing that it would be contrary to accepted medical practice to do otherwise.

It would be relatively easy to add a "Type D" to this list, where certification is required from the admitting specialist before admission into an overnight facility.

It would be possible to slowly add MBS item numbers to the list, and thereby trial the solution and allow providers time to adjust to this new requirement.

There are several disadvantages to this option:

- It would face powerful resistance from those who would be disadvantaged – the large groups of private overnight hospitals.
- The ability of the lower cost hospitals to respond to the increase in patient volumes would need careful capacity management (see discussion of Capacity below in section 3)
- Some specialists are unlikely to appreciate the additional requirement on their practice.

2.2.4. Transparency

The information that specialists require to make informed choices about the cost-effectiveness of their venue of care options is hidden from them. Transparency in what private health insurers pay private hospitals for procedures may give specialists cause to consider the overall impact of their choice on the viability of private healthcare.

This would require making information that is currently considered confidential by the private health insurers, more widely known. This is something of an anathema for the private health insurers. However, the prices that they pay to one set of providers (doctors) is public, while the prices that they pay to another set of providers (hospitals) is highly confidential. It is worth investigating and understanding why this is the case and addressing the confidentiality concerns.

At present, the private health insurers share the prices that they pay to hospitals with the department of health in the form of episodic data. These prices are not generally known within the medical community.

Given the medical community's great capacity for change, and the desire to maintain the viability of the private healthcare sector, requiring hospitals to share with credentialed doctors the prices that the hospital receives from payers may engender enough behaviour change to achieve a sizeable proportion of the available savings.

This sharing could be limited to the prices for practice-relevant procedures in each case – i.e. ophthalmologists would see their hospitals' prices for cataract removal and IOL insertion, vitrectomy, and trabeculoplasty.

2.2.5. Parity

A far simpler option would be to reset pricing so that each hospital is paid the same rate for any given procedure.

This would remove the need for specialists to consider the impact of choice of venue of care on the financial viability of private healthcare and would likely substantially reduce outgoings for the private health insurers. It would also substantially remove the confidentiality issues for payers.

There are perhaps two main methods to put private healthcare back on a path of equal payments for a given service: removal of the mechanism that supports differential payments, and regulation towards equal payments.

The first is to remove the categories of hospital from the second-tier default benefit calculations in the Private Health Insurance (Benefit Requirements) Rules 2011. The existing artificial and arbitrary divisions support differential pricing. Its removal would slowly transition the sector to price parity as non-contracted hospitals would see their prices change based on an average across all hospitals. The disadvantage of this approach is that it is more likely to increase prices at the lower end of the market without impacting the top end, rather than bring pricing towards an average value. In this way it is likely to have an inflationary impact on private health insurer outgoings.

Perhaps a better way is through regulation. An addition to the Private Health Insurance (Benefit Requirements) Rules 2011 could stipulate that for any given treatment, every hospital provider must receive the same reimbursement. Each insurer or their negotiating agent is able to choose and negotiate this reimbursement but must apply it consistently across all of its contracts with hospitals. This would also give private health insurers the opportunity to reset their pricing in order to remove some of the perverse incentives which exist at present (e.g. the oversupply of some procedures, and undersupply of others).

2.2.6. Transmission of pricing signals

The structure of the private healthcare sector prevents Adam Smith's invisible hand from working as it does in competitive markets. This is because price signals are prevented from having an impact on behaviour.

Restructuring the market for private healthcare would be a monumental undertaking with enormous resistance to change from many sides, and so we offer these ideas as thought experiments, rather than as serious suggestions for near-term change.

In a normally functioning competitive market, the person who pays for the product or service also benefits from the product or service and has the ability to weigh up the products or services from multiple suppliers against the prices before making a decision.

Some segments of the medical community operate in this way already – most notably aesthetic surgery and in some cases dental surgery. This is not coincidentally because these treatments do not fall under Medicare.

There are two obvious ways of improving the transmission of pricing signals.

The first is that private health insurers agree a lump-sum payment with admitting specialists, and admitting specialists are then responsible for selecting and paying the other medics (anaesthetist and assistant), the hospital, and for any implants that are used.

This provides an incentive to the admitting specialist to choose the venue of care wisely, as this will impact the margin that the specialist retains for that episode of care.

Several immediate disadvantages are that:

- some doctors will make up any perceived shortfalls with higher medical gaps,
- there is a strong incentive to drive costs down below an ideal level – e.g. by use of low cost consumables and implants.
- It places a large additional administrative burden onto the specialist's practice

It may however allow a specialist to offer some options to suitable patients: no or low gap treatment at a low-cost venue of care, but a gap will be charged to the patient if the patient opts for a higher cost venue of care. This then transfers some of the price signal to the patient.

The alternative to this arrangement will be less well received by the medical community and may be in conflict with s51 (xxiiiA) of the constitution. This would be where the hospital receives the same lump sum from the private health insurer and is required to negotiate medical fees with the specialist, the anaesthetist and the assistant, if any. Private hospitals would be able to compete for work from health insurers on these prices.

3. Capacity

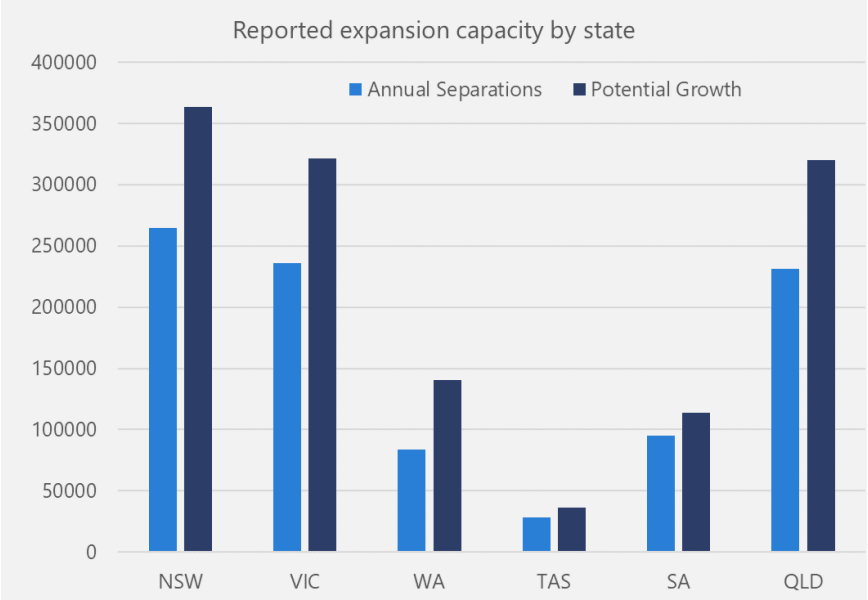
3.1. Background

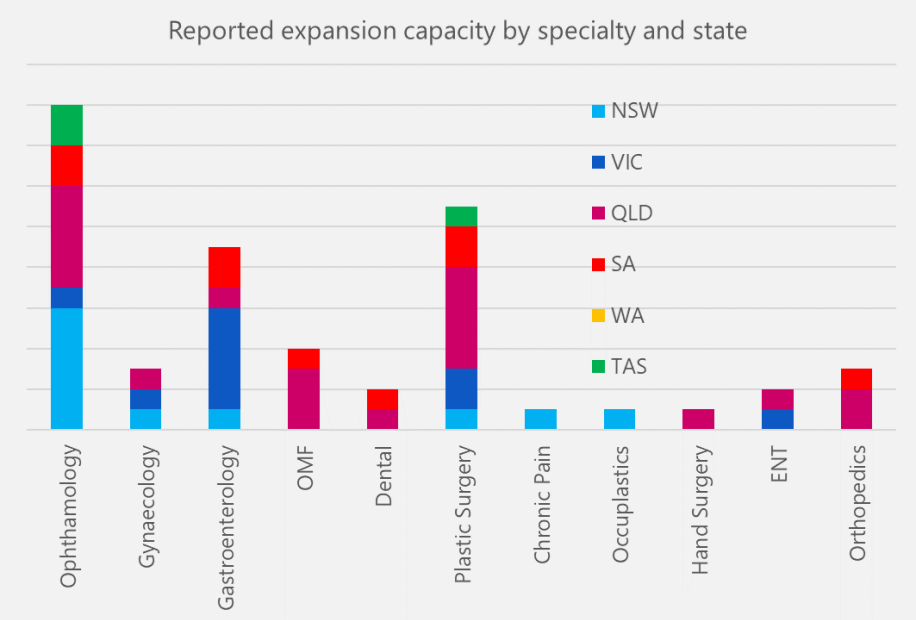
Any approach to ensuring that patients are guided towards the most appropriate venue of care must take into account the ability of low-cost providers to absorb the additional volume of patients, given their existing capacity constraints.

Some underutilised capacity exists in the day hospital sector, such that accepting higher volumes of patients for same day treatments is feasible, but a phased plan would be required.

An informal survey of Day Hospital Australia members suggests that significant underutilised capacity exists in the day hospital sector. The sector undertook almost a million procedures during 2022-23, with 667,000 of those funded through private health insurance. Based on the results of the informal survey, as much as an additional 300,000 patients could receive treatment annually in day hospitals.

Of the 763,000 patients treated in overnight hospitals with the same-day procedures highlighted in section 1.5, up to 40% of them could be treated now in lower cost facilities.





3.2. Matching the transfer to capacity

Regulatory changes which mandate a change in behaviour require that the behaviour is possible. A key concern for regulators is the ability of the industry to adapt to changing regulation. While our estimates indicate the day hospital sector's ability to absorb 40% of the required volume, this excess capacity is specific to both location and specialty.

Any regulatory change would require a substantial notice period to allow providers to adapt to the future situation. However, two noteworthy pieces of healthcare regulation over the past five years have been wound back or softened before implementation. These are the General Use Items removal from and reinstatement to the Prescribed List of Medical Devices and Human Tissue, and the implementation of AS/NZS 4187:2014, in the form of 10 versions of AS 18/06 released by the Commission for Quality and Safety in Healthcare. Without making any comment on the merits of the final outcome, it can be said that the regulatory process in these cases was not optimum – particularly in the investments in time and funds to prepare for scenarios which did not ultimately occur. Prevention of this in the present case is important.

Further research is required among the community of low-cost providers to better understand capacity available by specialty, both now and in the future.

Implementation of (for example) a type-D arrangement could be done by:

1. Starting with a small number of MBS item numbers, and adding to this list over time
2. Offering a two-year lead time before implementation of the regulation for each MBS item number
3. Undertaking a one-year ramp up of enforcement of the requirements for a type-D certification (following on from the two-year lead time)

Specifically, the first MBS item numbers which could be considered include:

a. 42702 – cataract removal and IOL insertion
b. 32222 - 32229 – colonoscopy
c. 30473 – 30478 – gastroscopy

The annual financial impact of these three procedure groups is $300m.

3.3. Incentive and information-based options

The incentive and information-based options:

- Differentiated MBS benefits and gap cover benefits,
- Transparency of provider pricing, and
- Parity of provider pricing

require less careful management of the implementation. These changes could be affected rather rapidly, and the private hospital sector would adapt to the level of patient volume shift that the change induces.

A cost-benefit analysis may be required to determine whether the impact of these potential changes would be positive. The analysis could answer whether the proposed changes would induce enough change to save the private healthcare sector money, and whether the resistance to change from within the sector will allow enough volume shift.

4. Appendix One

4.1. Introduction

Section 1.4 included an outline of the situation and trends within gastrointestinal endoscopy, chemotherapy and ophthalmology. The procedures outlined below are those not discussed above in section 1.4.

4.2. Carpal Tunnel Release

The vast majority of carpal tunnel release procedures are undertaken in overnight hospitals. Overnight hospitals undertake almost eight times more carpal tunnel release procedures than day hospitals. This is likely because the majority of specialists performing this procedure (neurosurgeons, orthopaedic surgeons and general surgeons) spend most of their operating time in overnight hospitals.

This imbalance (shown in Figure 11), combined with the cost difference (shown in Figure 12) means that there are significant savings available to the private healthcare sector.

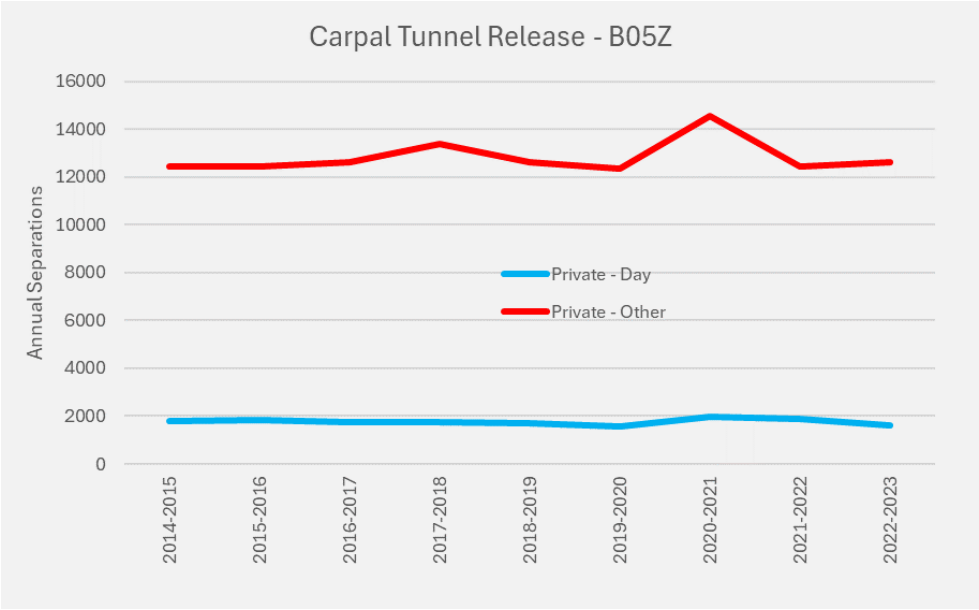


Figure 11: Patient volume for carpal tunnel release: day hospitals and overnight hospitals

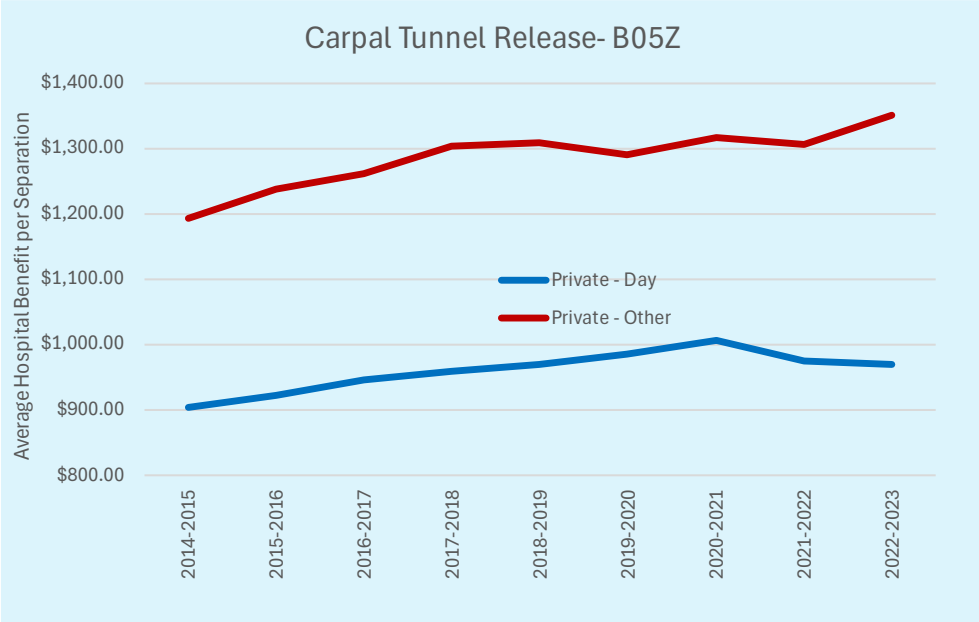


Figure 12: Difference in Benefits: day hospitals and overnight hospitals

Overnight hospitals are paid approximately 35% more for carpal tunnel release procedures, and this gap has also remained reasonably constant over time – although widening to 40% in the most recent data.

Because the volume of carpal tunnel release cases in day hospitals is not high, the cost increase to the sector of day hospitals disappearing is relatively low, however there is a 26% cost saving available to private health insurers if these cases move to day hospitals. Over 96% of carpal tunnel release procedures in overnight hospitals are done as day cases.

The private healthcare sector would save $5m if specialists took these procedures to day hospitals.

4.3. Dental Surgery

Dental Surgery is performed by dentists who have undertaken additional surgical training over and above their undergraduate dentistry studies. Often, patients are brought into a theatre for dentistry under sedation due to the complexity of the procedure (e.g. implants) or the inability of the patient to tolerate dentistry (for example, special needs young people).

A large majority of these procedures are undertaken in overnight hospitals, despite almost 99% of these admissions to overnight hospitals being same-day cases. However, it appears that the proportion of cases in day hospitals is increasing over time – the volume of dental procedures in overnight hospitals has reduced by 10% over the time period in Figure 13, while the volume has increased by 8% in day hospitals.

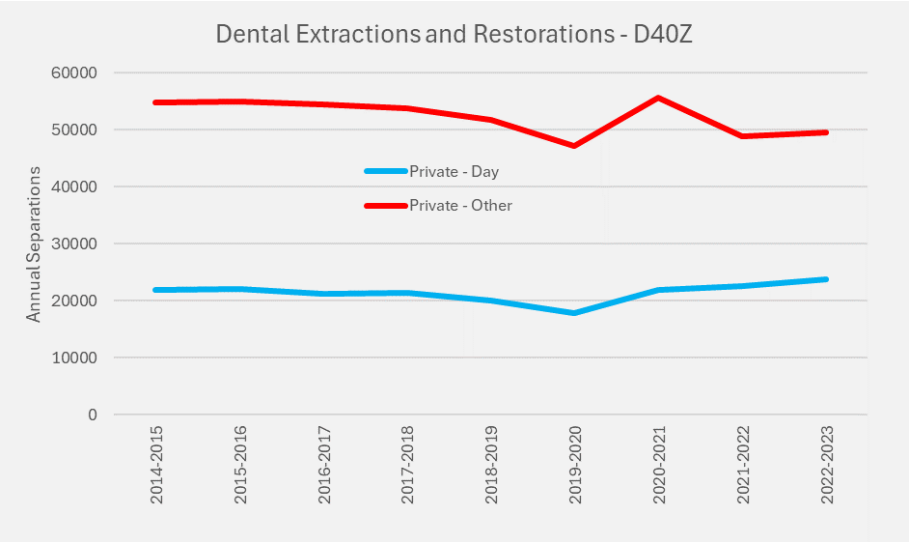


Figure 13: Patient volume for dental procedures: day hospitals and overnight hospitals

One reason for this is that dental surgeons have reduced ability to obtain theatre time in overnight hospitals due to the low-to-negative gross margin available from dental procedures. Note that this information is merely anecdotal, rather than being backed by data.

The average benefit to overnight hospitals has increased by 27% since 2014-15, while day hospitals received approximately half of that percentage increase.

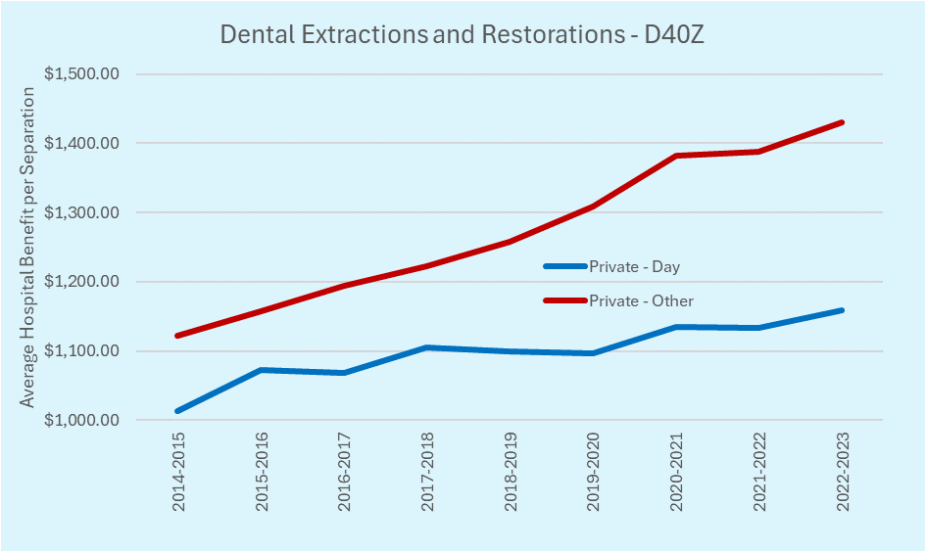


Figure 14: Difference in benefits for dental procedures: day hospitals and overnight hospitals

Over 73,000 patients per year are admitted for private in-hospital dental surgery. This high volume of patients amplifies the difference in benefits paid and means that the available saving for private healthcare is over $13m per year, if dental surgeries were undertaken in day hospitals. The sector could expect to pay an additional $6M if day hospitals stopped undertaking these procedures.

4.4. Cystoscopy

The DRG L44B is driven by a wide range of urinary disorders, while the majority of related interventions are cystoscopy or ureteroscopy. day hospitals are typically not equipped to undertake the image guided variants of these interventions, although this is a small proportion of the total procedures, and some day hospitals are installing this equipment.

Day hospitals undertake less than 7% of these procedures, while 95% of patients admitted to overnight hospitals for this DRG are discharged same-day.

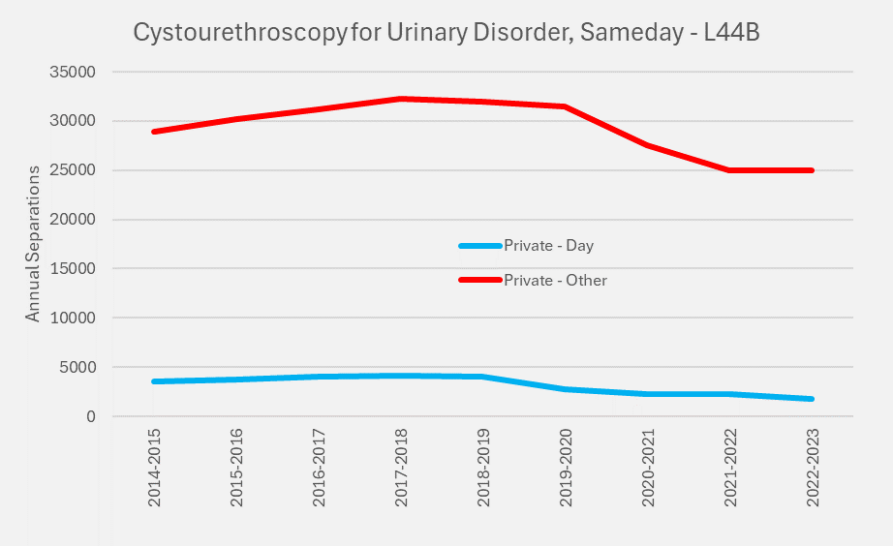


Figure 15: Patient volume for cystoscopy/ureteroscopy: day hospitals and overnight hospitals

Private health insurers pay overnight hospitals an additional 66% for these procedures compared to day hospitals. A small amount of this difference may be explained by case mix.

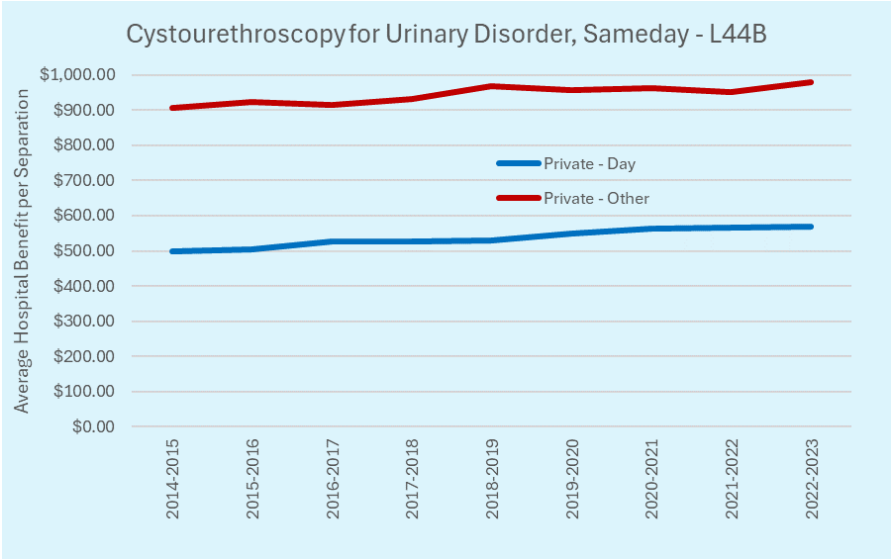


Figure 16: Difference in benefits for endoscopy procedures: day hospitals and overnight hospitals

Doing all of these procedures in day hospitals would cost $15m annually, while doing all of these procedures in overnight hospitals would cost $25m annually.

4.5. Haemodialysis

Day hospitals undertaking dialysis are generally highly specialised facilities, operated by international companies that are also supplying equipment and infrastructure for this treatment.

Over 98% of patients admitted to overnight hospitals for dialysis are discharged same day, while over 55% of dialysis patients are admitted to an overnight hospital. As recently as 2014, more patients were admitted to day hospitals for dialysis than overnight hospitals. Over the period shown in Figure 17, the number of patients admitted to day hospitals has increased by 25%, while overnight hospitals volume has increased by 70%.

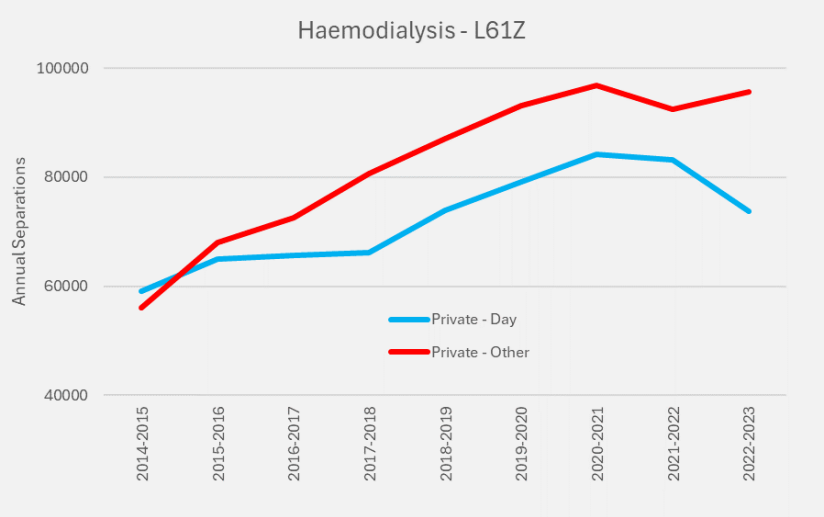


Figure 17: Patient volume for haemodialysis: day hospitals and overnight hospitals

Unusually, the average benefit paid to overnight hospitals has declined by a fraction over the time period shown, due to an apparent average price reduction for overnight hospitals in 2015. The average benefit paid to day hospitals has increased by almost 9% over the same period but remains more than 25% below the benefit paid to overnight hospitals.

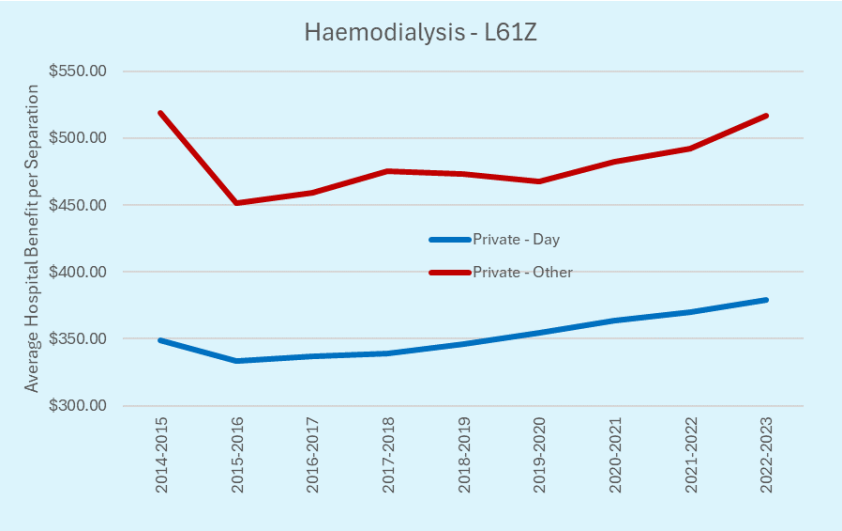


Figure 18: Difference in benefits for dialysis procedures: day hospitals and overnight hospitals

The operators of most of these day hospitals are Fresenius Medical Care and B Braun – two extremely large German medical device and pharmaceutical manufacturers. They are unlikely to be impacted by these benefit differences in the same way as other day hospitals, but should day hospitals operators exit this market, the increased cost to private health insurers is $10m annually. If all dialysis sessions were undertaken in day hospitals, the private health insurers would save $13m annually. The gap between these two is $23m.

4.6. Diagnostic Curettage and Diagnostic Hysteroscopy

Curettage within this DRG group of interventions is performed to provide biopsies of the uterus, while hysteroscopy is a visual examination of the uterus – these can be performed separately or together.

All but 2.5% of women admitted to an overnight hospital for this procedure are discharged the same day, and almost 90% of women admitted to any hospital are admitted to an overnight hospital. This imbalance, like a few other procedure groups discussed in this report, is likely mostly due to the apparent preference of most gynaecologists for overnight hospitals.

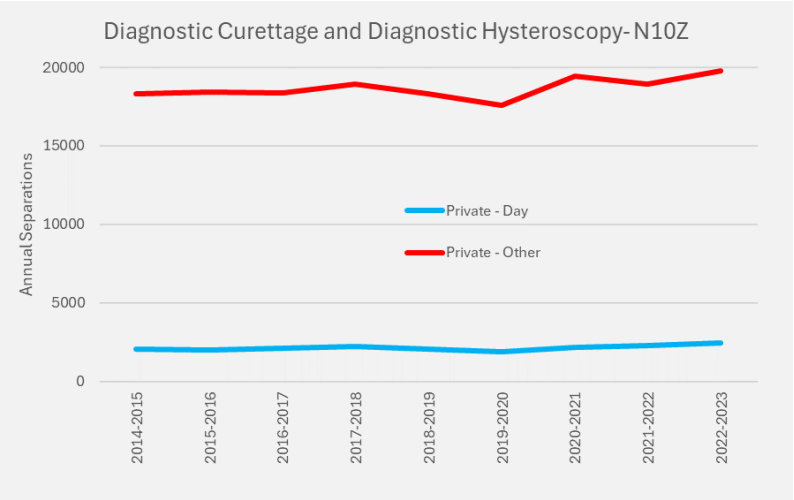


Figure 19: Patient volume for curettage and/or hysteroscopy: day hospitals and overnight hospitals

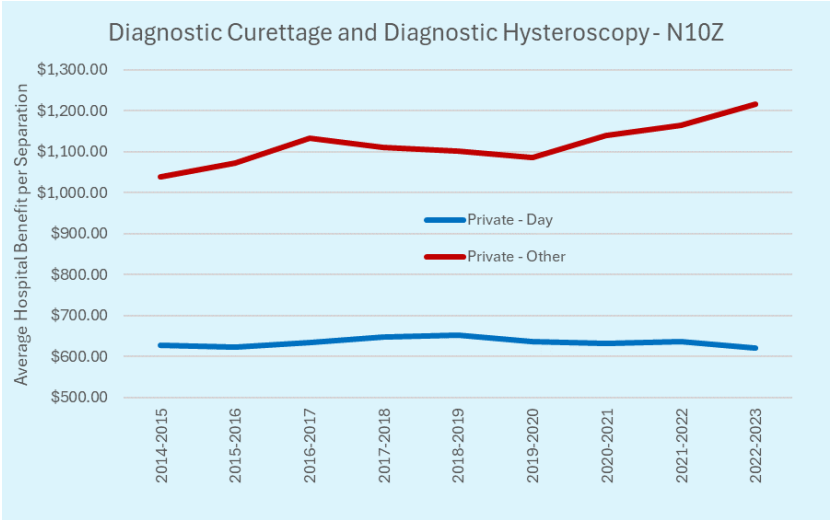


Figure 20: Difference in benefits for curettage and/or hysteroscopy procedures: day hospital and overnight hospitals

Private health insurers pay 85% more to overnight hospitals than to day hospitals for this group of procedures, as shown in Figure 20. This means that a $10m saving is available to the private healthcare sector, were these procedures done in day hospitals, while the additional cost of 100% of these procedures being done in overnight hospitals is $1.3m.