Outpatient surgery—An alternative to hospitalization

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Given the premise that health care is costly and that concepts about the amount of time and hospital care needed after surgery are changing, the author explores the surgicenter and outpatient surgery as possible alternatives.

The phenomenal rise in the cost of health care, a medical practitioner shortage, and waste in health care indicate a need for new alternatives. This article, therefore, will explore the surgicenter as a feasible alternative to current practices. Today, as more and more consumers are complaining about the overuse of hospitalization, the high cost of medical care, and the inefficient delivery of services, a separate facility to handle minor surgery seems to be a logical solution to one of the major problems of the 1970's.

Old concepts about the amount of time and hospital care needed after surgery are changing. Surgicenters are helping patients profit from these changes, physically and financially. In addition, it would appear that patients receive more personal, efficient care in a more inviting atmosphere. Surgicenters can ease the burden on acute care hospitals and give consumers the kind of care they are clamoring for.

Why must the consumer of health care services seek alternatives to the present system? In the initial phase of this article, the author seeks to identify specific factors as well as fundamental problems related to our present system of health care delivery in the United States. The latter half of this article will present the surgicenter as a logical alternative to our present system.

Introduction

Never before in the history of the United States have so many Americans enjoyed such an abundant amount of good health care. A great many Americans no longer consider health care a privilege for those who can afford it; indeed, they consider it a right.

Even those who do not consider health care a right strongly object to the soaring costs of health services. The sustained rise in the cost of health care in the United States is one of today's major political and economic issues. It is also a matter of increasing concern to all members of the health care community, both private and public. Escalating health care costs have been disproportionate to that of other service items in the Consumer Price Index.

The Council on Wages and Price Stability reported that health care costs rose 10.3% in 1975, while that for other items in the Consumer Price Index went up 7.7%. The council also reported that the average American spent $547, or almost 10% of his income on health care in 1975. How do we slow down the escalating cost of providing good health care? Such costs for health care...
are up 77% as compared to 59% for the general cost of living based on the Consumer Price Index for the 1967 level.4

At the present time, there are at least a half dozen different proposals for National Health Care Insurance being considered by Congress. During the remainder of 1978, there will be increasing pressure on Congress to act on one of these proposals.5

The economically disadvantaged should not be deprived of needed health care simply because of economic circumstances; and no one should suffer financial disaster because of catastrophic medical bills. A great deal of progress has been made in the past 12 years toward the goal of affording protection to all Americans against these burdensome medical bills. The passage of government medical insurance for senior citizens, better known as Medicare, marked a turning point in federal concern about health care delivery in the United States. In the past 11 years, the number of Americans having private insurance, Medicare, Medicaid, or other forms of government assistance rose from 73% of the population to 90%.6

While such progress has afforded many Americans better health care, it has given rise to another problem that is of increasing concern to citizens and health care providers alike. From 1965 to 1975, total spending on health care increased from $39-billion per year to $115 billion.7 The health care industry is presently one of the largest in the United States, representing 7.8% of the 1974 gross national product. It is one of the fastest growing segments of our economy.8

Reasons for rising costs

Why this dramatic increase in the cost of health care delivery in the United States? An article in the U.S. News and World Report states that there are multiple causes, but that the chief reason is to be found in the way health care is organized, financed, and delivered in this country. The present method provides strong cost-increasing incentives.12

In an address to the Mississippi Association of Nurse Anesthetists, William F. Bush, a leading hospital administrator likened our present health care delivery system to a giant sponge, in that the system can legitimately soak up every dollar that can be poured into the system.18

Mr. Bush went on to deal with some of the specific factors that have contributed to the increasing costs. One of the basic problems is the serious over expansion of bed capacity in present hospitals and the building of hospitals where they are not needed, particularly in the urban areas. This over expansion results in a lower patient census for each hospital in the community. Mr. Bush went on to point out that most hospitals need a 70% occupancy rate just to break even. When they fail to achieve that occupancy rate, they are forced to raise the daily charge for a bed in order to meet costs. The average cost per patient day may range from a national average of $130 to as high as $456 in the case of one of the hospitals in New York City, which has a daily occupancy rate of 62%.14
Another not so visible cost factor is the increasing reliance on expensive technicians outside the hospital who are required to service all of the expensive hardware contained in today's modern hospital. The engineering staffs of a great many hospitals simply do not have the technical knowledge required to deal with much of this equipment. In fact, much of this equipment is so complicated that the company that builds it must provide the technical expertise to service it. Dr. Max H. Parrott, a former president of the American Medical Association summed it up this way:

"No one can master all the tools a doctor has at hand today. Health care today is a matter of teamwork. People have come to expect miracles and compared to what doctors could do 30 years ago, miracles are at hand. But no one man can perform them all."

Current estimates are that over 90% of hospital costs are now paid by third parties. This cost reimbursement basis encourages many hospitals to buy expensive equipment for which there is little or no justification, simply because this cost can be passed on to third parties. This may be a major factor in the escalating costs of health care services today.

The health care consumer directly or indirectly pays his insurance premium and has every incentive to collect benefits that will help maintain his health. At the same time, the health care provider has every incentive to render those services, particularly if he is a physician involved in the fee-for-service system. The insurer, private or public, is caught between two opposing forces, and will suffer the wrath of both parties as a result of any attempted interference.

If the patient has a condition that requires treatment and that treatment is not reimbursable on an outpatient basis, then the physician and the patient conspire to beat the system. The end result is the use of high cost hospital facilities for services that could have been performed on an outpatient basis. While the patient gains a temporary advantage over the insurer, in the long run, this same patient will pay for services rendered in the form of increased premiums.

Surgery statistics

Dr. Paul Feldstein, professor, School of Public Health, University of Michigan, points out that following the introduction of Medicare and Medicaid, the annual rate of increase for surgical procedures was double that of the previous record. The period under study was 1966-1974. While it is very difficult to obtain hard figures on the total number of operations performed in this country each year, one can obtain estimates from two primary data sources. Hospitals, the journal of the American Hospital Association, publishes statistics based on sample surveys gathered each month from short-term general hospitals. The other source is the National Center for Health Statistics, Department of Health, Education and Welfare. Their statistics are derived from a national sample of hospital records of discharged hospitalized patients.

For 1971, the American Hospital Association reported 14,670,000 operations, while the Center for Health Statistics reported 15,774,000 operations. The difference of 7% is not unrealistic in view of the fact that these statistics are based on sample surveys.

Even more enlightening are figures published by the National Center for Health Statistics. They report that 7.7% of the general population had operations performed in short-stay hospitals in 1965 and 7.8% in 1971. Heilbroner estimates the population in the United States for these two periods at 193 million and 205 million respectively. On the basis of these statistics, one could assume that there were 14,861,000 operations in 1965, and 15,990,000 in 1971. These two projections are remarkably close to the previously mentioned estimates by the American Hospital Association and the Center for Health Statistics.
Are all of these operations justified? Perhaps we should reevaluate current practices, and change the system. A major portion of health services should be shifted away from the curative aspects to the preventive areas of health care. Any significant reduction in the number of operations performed would result in an enormous amount of savings that perhaps could be better utilized in improving the quality of health of our citizens.

It is becoming increasingly obvious that much of the surgery that is needed does not require that the patient be hospitalized. Outpatient surgery is a logical alternative to the present system to which we are locked in. Outpatient surgery can, and does provide, a feasible alternative to the present system of expensive and unnecessary hospitalization.

**Outpatient surgery as an alternative to hospitalization**

Outpatient surgery has been given a number of popular names. It is also known as "ambulatory surgery," "in-and-out surgery," "short-stay surgery," "day surgery," "mini-surgery," and "surgicenter." The surgicenter is a unique and innovative type of facility that has met with great success in many parts of the country. It serves the medical community and the consumer by providing a professional surgical facility that is not dependent upon hospital bed space. It serves the medical consumer by offering an alternative to costly hospitalization and disruption of normal family life. On the basis of previously mentioned statistics, the potential savings for the medical consumer are enormous.

To dispel two popular misconceptions regarding outpatient surgery; it is not new and it did not originate in this country. As early as 1909, Nichol reported on 7,000 children undergoing surgery as out-patients between 1899 to 1909 at the Royal Glasgow Hospital for Sick Children.25

Although outpatient surgery has been performed on a limited scale in this country for many years, particularly by oral surgeons, current discussions in the literature focus on conceptual changes that now account for its increasing popularity.

The early popularity of outpatient surgery that Nichol reported on was due to two factors. First, there was an acute shortage of hospital bed in Glasgow and, therefore, it was necessary to get patients in and out of the hospital as rapidly as possible. Moreover, further perfection and refinement of local anesthesia and local anesthetic techniques developed by William Halstead in America made it possible to use local anesthesia, rather than general anesthesia for many of these operations.26

The recent resurgence of interest in this subject can be directly attributed to two factors. First, the nearly universal concern with the rising cost of health care which is one of today's major political and economic issues and, secondly, the development of general anesthetic agents and techniques that allow lighter levels of anesthesia, and a much safer and shorter recovery period.

Outpatients should be afforded the same quality of care administered to inpatients without such inconveniences and potential hazards as the disruption of the family unit, and exposure to hospital cross infection. Dr. Jay F. Lewis, a noted authority on hospital acquired infections, and a member of the Examination and Standards Committee of the American Board of Microbiology, estimates that 1 out of every 20 patients entering the hospital will develop a hospital acquired infection.27

What are the conceptual considerations and criteria for a successful and safe outpatient surgical unit? First and foremost, there must be a clear and concise administrative operational plan. This plan would entail a general description of the outpatient surgery program, along with minimum standards required for outpatient surgery such as, a history and physical examination, appropriate x-rays, laboratory tests to be performed,
instructions to be given to the patient, and so on. It should also contain an outline of the clinical management protocol, along with the flow pattern of patients through the outpatient surgery unit.25

In 1971, Medical World News reported that 20% to 40% of all surgical procedures could be safely done on an outpatient basis. Just how safe are procedures done on an outpatient basis? Medical World News points out that the independent type has an excellent record of safety. The surgicenter in Phoenix, Arizona reports that more than 5,000 outpatient operations were performed between January, 1970 and October, 1971 with no deaths, and only one complication that resulted in a patient having to be transferred to a hospital.26

By way of comparison, Epstein reports a 1% complication and necessity for hospitalization in 14,000 outpatient surgeries performed at George Washington University Hospital from March, 1966 through December, 1971. No deaths were reported.30

The potential economic savings that could be derived from utilizing outpatient surgery stagger the imagination. Davis states that there are more than 70 different operations involving 10 different surgical specialties that are being done on an outpatient basis.31

The savings per patient at the surgicenter in Phoenix were reported to be an average of $130 per patient, or $650,000 saved by and for 5,000 patients over a 19 month period.32 On the basis of 15,990,000 operations performed in 1971, even the minimum figure of 20% would yield a figure of 3,198,000 operations that could have been done on an outpatient basis. The reported average cost per day in a hospital in 1971 was $64.00.33 Using this figure to compute a minimum of two days hospitalization, which is certainly conservative, this would amount to a savings of more than $4 billion.

Egdahl reports that the Department of Defense has approved outpatient surgery centers for military payment.34 While the acceptance of the outpatient surgery concept by the patient (first party) and the provider (second party) has been excellent, this is not always the case with the insurer (third party). There is obstructive refusal by some insurance carriers to pay for outpatient surgery. Egdahl reports that this is beginning to change and that many insurance carriers are beginning to write optional plans that allow outpatient surgery.35

The case for surgicenters

Are outpatient surgical facilities deserving of the increasing praise and popularity heaped upon them? To better answer this question the author of this paper made a field trip to a large southern city to observe some of the desirable operational characteristics of a successful independent free-standing surgicenter.

Location. The location of any surgicenter is of prime importance. It must be centrally located to ensure easy accessibility to patients, staff, and transportation. There must be adequate parking facilities with provisions for transporting patients in wheelchairs. Entrance and exit points should be under cover to protect the patient in inclement weather.

The outpatient surgical facility visited (hereafter referred to as the surgicenter) is a modern facility that more than meets the above criteria. It is in a centrally located residential area of the city directly across the street from a hospital. The surgicenter occupies an entire floor of a modern professional building. There was valet parking off of the main lobby entrance, or self parking at various floor level.

Physical facilities. On entering the surgicenter reception area, one is almost startled. Gone are the preconceived ideas of what a typical surgical facility should look like. One enters into a very plush foyer that opens on to what appears to be an oversized living room in

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a very affluent private home. The entire area is thickly carpeted and furnished in a very tasteful manner. The emphasis is on comfort. There was soft background music, and a pleasant greeting by the receptionist.

The manager of the surgicenter, Mrs. Daniels, informed me that a great deal of preliminary planning and design was carried out well in advance of the actual construction. The floor plan of the surgicenter provides for smooth delivery of the care which is offered, with a complete separation of the operating rooms, sterile areas, and supporting facilities. Even more impressive was the flow of patients from point of reception to point of discharge. In addition to the reception area there are 4 large operating rooms, an admitting area, dressing rooms, storage and work area facilities, and 2 recovery rooms which provide for separation of children from adults during the recovery room phase.

**Administration.** The surgicenter is the first free-standing ambulatory surgical facility built in the deep south, although a local hospital is in the process of establishing such facilities. The surgicenter was conceived and developed in concert with private investors and local physicians as a community-oriented, privately-owned outpatient surgical facility. The philosophy of the surgicenter is expressed in the brochure that is given to each patient. Briefly stated, that philosophy is to provide quality professional care in a considerate and personalized manner. Aside from removing the need for unnecessary hospitalization, the surgicenter provides the convenience of flexibility in scheduling surgical procedures at times which are both agreeable to patient and attending physician.

Implied, if not expressed, is the philosophy that the surgicenter is a private enterprise that seeks to make a reasonable profit by providing a needed service. Chances are excellent that it will succeed, since the facility has been approved for outpatient surgery for Medicare and Medicaid patients, as well as many major insurance contractors.

The surgicenter had already won approval by the Comprehensive Health Planning Council of the state.

The surgicenter has voluntarily developed a Medical Audit Team of well qualified and highly respected community physicians who have no vested interest in the facility. The Medical Audit Team makes recommendations governing the medical policies of the surgicenter. There is also an Audit and Utilization Committee that monitors the quality of medical care through a quarterly review.

**Patient input.** As is traditional with inpatient surgical procedures, the patient selects the surgeon who arranges for scheduling at the surgicenter. The preoperative evaluation of the patient is performed by the patient's own physician. Laboratory tests and x-rays are usually done in the referring physician's office, although they can be done at the surgicenter.

The attending physician gives the patient the surgicenter brochure which is designed to provide the patient with general information as well as specific instructions. The brochure covers such information as to what to wear, restrictions on eating and drinking prior to surgery, what forms are needed, the average length of stay at the surgicenter, and so on.

The receptionist at the surgicenter also contacts the patient at home and answers any additional questions that the patient might have. This also provides the receptionist with information that helps keep the admitting time to a minimum at the time the patient checks into the surgicenter.

Since I wanted to gain a patient's perspective of outpatient surgery, I elected to follow one patient throughout most of a surgical procedure. The manager of the surgicenter made the necessary arrangements to interview and accompany the patient. To protect her privacy, let us call her Ms. Cathy Jones. Cathy was a charming young lady with a diagnosis of impacted wisdom teeth. My ability to communicate with Cathy
was somewhat limited, since she suffered from a moderate hearing loss. Cathy’s mother took care of filling out the required admission data which was accomplished in a minimum of time. Our first stop after admission was the patient holding area.

Cathy was shown to a dressing room where she changed into a lightweight disposable surgical gown. In a short time the anesthetist assigned to her came by, introduced himself, and explained the process of putting her to sleep. The anesthetist carried out a preanesthesia history and evaluation, listened to her heart and lungs, and then started an intravenous infusion. I could not help being impressed by the ease in which he made Cathy feel comfortable and secure. In a short time Cathy was moved to the operating suite. I did not accompany Cathy through the operating phase, as I wanted to utilize this time in getting her mother’s impression of outpatient surgery.

I asked Cathy’s mother what she saw as the chief advantage of a facility such as the surgicenter. Aside from economic factors, she spoke at some length about Cathy’s hearing problem and the fact that she felt that this might create a communication problem were she hospitalized. She also expressed the viewpoint that she felt that hospitals were places for the ill and in need of a lot of care, and that this was not the case with Cathy. She then made an important point that I had completely overlooked. That point being that many hospitals in this particular city are located in areas of crime and violence. She went on to say that while she considered them relatively safe during daylight hours, she was afraid to visit friends or relatives during the evening hours.

Some 35 minutes later, Cathy arrived in the recovery room. She was beginning to awaken upon arrival and, a short time later, was aware of where she was and that her surgery had been completed. Two hours after her arrival in the recovery room, she was discharged to her home. Cathy’s mother was given instructions outlined in the surgicenter brochure which covers information pertinent to the recovery period at home.

All patients of the surgicenter receive a follow-up phone call from a surgicenter nurse the following day and this is noted on their chart. There seems to be a genuine interest on the part of the staff that patients receive a great deal of personalized attention and care. The patient is made to feel like an individual, which is as it should be, but often is not, in a great many large and impersonal institutions.

In order to determine the economic advantages to the medical consumer in using an outpatient surgical facility: I made arrangements to interview a person I shall call Mr. George M. Roman, who is manager of Surgical Services at a local hospital. For purposes of comparison, 5 surgical procedures that are commonly done on an outpatient basis were selected. The objective of this study was to carry out a comparative cost analysis for each of these procedures at the surgicenter and the local hospital.

In the hospital, setting it was not only necessary to determine the cost for each of these procedures, but also to determine the room cost and period of hospitalization as an inpatient. By using rather extensive computer studies, Mr. Roman was able to supply this data. One should bear in mind that these projections and data apply only to this particular hospital and surgicenter, and should not be construed as being representative of other surgicenters and hospitals in other areas.

Comparison cost data between the surgicenter and the hospital are outlined in Table 1. Note that there are no separate charges listed in Table 1, for use of the recovery room and operating room supplies at the surgicenter. At the surgicenter, a single basic charge is set for each procedure so that the patient and surgeon as well as the insurance carrier will know in advance what the cost will be. Fees for professional services by the surgeon, anesthetist, and...
### Table 1
A comparative cost analysis

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<tr>
<th>Procedure</th>
<th>Operating Room</th>
<th>O.R. Supplies</th>
<th>Recovery Room</th>
<th>Room Charge</th>
<th>Average Length of stay (days)</th>
<th>Total Cost</th>
<th>Percent Savings</th>
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<tbody>
<tr>
<td>Surgicenter D &amp; C</td>
<td>$175.00</td>
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<td>0</td>
<td>0</td>
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<td>$55.00</td>
<td>$25.00</td>
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<td>2.3*</td>
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<tr>
<td>Surgicenter Laparoscopy (diagnostic)</td>
<td>$231.00</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>$231.00</td>
<td>37%</td>
</tr>
<tr>
<td>Hospital Laparoscopy (diagnostic)</td>
<td>$150.00</td>
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<td>$140.00</td>
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<td>$370.00</td>
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<td>Surgicenter Inguinal Hernia Repair</td>
<td>$278.00</td>
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<td>0</td>
<td>0</td>
<td>$278.00</td>
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<td>Surgicenter T &amp; A</td>
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<td>0</td>
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<td>1</td>
<td>$175.00</td>
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*Note: No additional charge for fraction of a day spent in the hospital.*

Pathologist are not included as they are billed separately.48

### Summary and conclusion

Unless we find a way to eliminate waste and control costs, our present system of first rate health care will not survive. Clearly much of this waste and inefficiency is due to lack of intelligent planning that to this day results in costly duplication of health care facilities and equipment. A prime example of this lack of intelligent foresight can be found as recently as June, 1976 when dedication ceremonies took place for the $100 million Cedars-Sinai Medical Center in Los Angeles—a city in which the average occupancy rate of hospital beds was already at a low 65%.44

Hopefully, the 1974 National Health Act will put a stop to this uncontrolled waste of our health resources. Under provisions of this act, the federal government has appointed an agency in each state which will prepare a master health plan for the state. In effect this means that no new hospital beds or major equipment can be added without first filing a certificate of need, in which case there must be proof and justification that such hospital beds and major equipment are needed in the community.45

Inasmuch as a major portion of the health care dollar ($40.9 billion—39%) is spent on costly hospitalization, then why not turn to more logical alternatives that do not require the construction expenditure of $30,000 to $50,000 per hospital bed?46

One such alternative that makes sense is the surgicenter. It is becoming increasingly apparent to the health profession and the public that a major portion of surgical procedures performed in hospitals can be done safely and economically on an outpatient basis. This author predicts that outpatient surgery can and will be, a major means of delivering quality health care at a lower cost.

### REFERENCES

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