

## Day Surgery Development

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In most developed countries around the world Day Surgery (Synonym: Ambulatory Surgery) is an important objective in order to maximise the utilisation of limited economic resources whilst still providing the highest level of quality treatment. In developing countries this may be the only possibility for treatment for many patients because of lacking resources.

Therefore International Association for Ambulatory Surgery (IAAS) is promoting day surgery activities in all contexts where it is applicable and wants to inform about day surgery possibilities and advantages to both clinical professionals and to governments/managers of health systems.

Day surgery in fact has a rather long history:

- The pioneer was Nicoll (1864–1921) a Scottish paediatric surgeon in Glasgow (*BMJ* 1909;753–6)
- In the 1960s in US the concept was used in hospital based facilities
- Around 1970 the first freestanding unit was opened
- A gradual development came in US, Canada, UK and Australia in the 1970s
- The first European congress was held in Brussels 1991
- The first international congress was organised 1995
- National associations were formed in US, Australia and most European countries during the 90's
- Since 1995 bi-annual international congresses has been organised by IAAS with between 1000 and 2000 delegates in different places in Europe and US

Today it is widely accepted by the member countries of IAAS that day surgery is a very important part of each countries health system, and in fact in many countries more than 50 % of all surgery is done in an ambulatory setting. However, it is still a developing field of health activity and the variation is great both within each country and between countries, and there are still a lot of countries who do not have organised activities – not necessarily meaning that there is no day surgery activity but there are no organisation for professionals and no register for activities.

In order to try to document some of the development the IAAS every second year conducts an international survey of day surgery activities. This project was started in the mid 90's with 20 surgical procedures and has now grown and changed into 37 procedures. These procedures are now:

### ENT

- Myringotomy with tube insertion
- Tonsillectomy
- Rhinoplasty
- Broncho-mediastinoscopy

### Eye surgery

- Cataract
- Squint

### Jaw surgery

- Surgical removal of teeth

### Gynaecology

- Endoscopic sterilisation
- Legal abortion
- Dilatation and curettage of uterus
- Hysterectomy by LAVH
- Repair of cysto- and rectocele

### Orthopaedics:

- Knee arthroscopy
- Arthroscopic meniscus operation
- Removal of bone implants
- Repair of deformities of the foot
- Carpal tunnel release
- Baker cyst
- Dupuytren's contracture
- Cruciate ligaments repair
- Disc operations

### General surgery

- Local excision of breast
- Mastectomy
- Laparoscopic cholecystectomy
- Laparoscopic antireflux surgery
- Haemorrhoidectomy
- Inguinal hernia
- Colonoscopy with or without biopsy
- Removal of colon polyps
- Pilonoidal cyst

### Urology

- Circumcision
- Orchidectomy or orchidopexy
- Male sterilisation
- TURP

## Plastic surgery

Bilateral breast reduction

Abdominoplasty

## Vascular surgery

Varicose veins

And the latest results regarding percentage of day surgery procedures in the basket in the surveys from the included countries were:

- Australia 74
- Belgium
- Canada (Alberta) 83.8
- Denmark 79.3
- England 62.5
- Finland 62.4
- France 44.9
- Germany 60.7
- Hong Kong 42
- Italy 41
- Netherlands 69.8
- Norway 68
- Poland
- Portugal 18.5
- Scotland 62
- Spain (6 reg) 54
- Sweden 66.7
- USA 83.5

The detailed percentages for each procedure can be seen at the IAAS website: [www.iaas-med.com](http://www.iaas-med.com) where both the newest results and the older ones are published. For the moment we are conducting another

survey with data from 2007 to be published at the international congress in Brisbane later this year.

The overall result of the surveys up till now are that US and Canada have the highest percentage of ambulatory surgery, the Scandinavian countries are close to the result from US, Poland and Portugal are rather low, and France and Germany in the middle. Still a lot of countries are unknown since we have no data. There are large differences between countries for the same procedures and also in total numbers and there are even large differences within the same country, between regions within a country, between counties, and between hospitals.

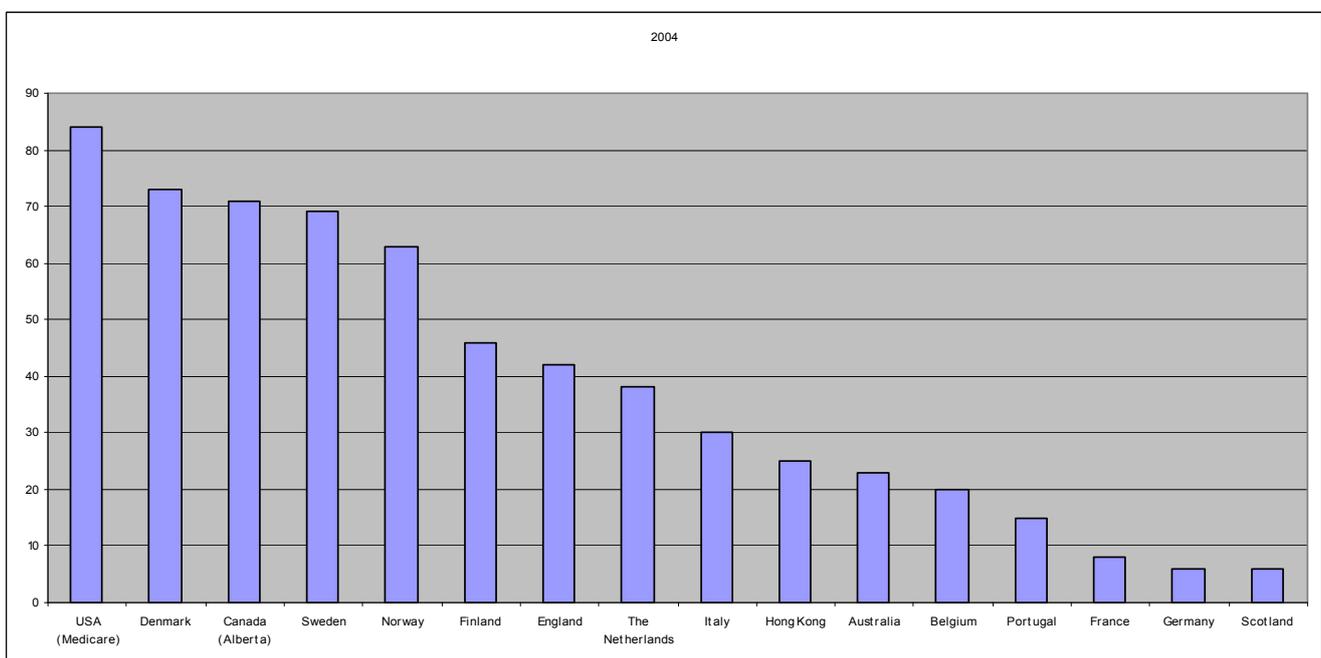
An example of the development could be the data for inguinal hernia repair where it is very visible and in fact difficult to understand that there is such a big difference between countries at the same level of development (Figure 1, below).

Why are there such big differences? That is of course the question to be asked and in fact also one of the reasons to make these surveys. One of the purposes for the survey is to make clinicians and also decision makers to wonder why there are such differences. That seems to be the main tool for development in many countries.

In my opinion there are many causes for the big differences. Tradition is an important one and unfortunately I have to admit that especially surgeons are rather conservative but also hospital managers and even patients can be difficult to convince. Culture is another aspect. It is very different how open minded and ready to try new methods people are, and some procedures can have a religious or traditional "overlay" that makes it unacceptable to do in a short stay procedure. Naturally incentives or the opposite also play an important role. Reimbursement can be better for inpatient procedures than for ambulatory, so the question is: Is there incentives to make changes? Or maybe the opposite? The organisation of the health system may also play a role. There can be a difference if the main part is public or private. In the private there is more focus upon efficiency that we often experience in the public sector – this may especially be the case in those countries that have had a sort of fundamentalist government.

But also more factual things may influence the development. Where the geography makes it difficult to get to and from the facility for treatment or where the traffic communication is lacking or difficult

Figure 1



this is a major barrier for ambulatory treatment. It is also necessary that the social security system is working so there is someone to take care at home after surgery. And last but not least the politicians have an important role: Is the item on the political agenda? Do the politicians try to move things?

Therefore it is very important for all the involved persons and parties that there are many advantages with the ambulatory treatment. For the patient the satisfaction is high, there are less hospital infections, and it is convenient and the quality is at least the same. For the hospital the function is well planned with lesser cancellations, there is a decreasing need for beds, and it is very cost effective. For the community the big advantage is the cheaper treatment and a better utilisation of closed emergency/inpatient facilities. For the staff it means teamwork, daytime work, increased skilled nurses and therefore a high satisfaction.

We think that IAAS has an important role to play in the development and inclusion of new countries in the development of day surgery. We exchange information and knowledge about the possibilities and the activities, we want to promote education and establish clinical guidelines and quality standards. We want to promote research and to give advice to colleagues and to other parties (e.g. governments, hospital boards etc.) For this task we find the International congresses the most important tool. But we have a lot of other activities to benefit from: We like to help organising National Associations. We

have a web site with information: [www.iaas-med.com](http://www.iaas-med.com) and an official journal "Ambulatory Surgery" published at the internet: [www.ambulatorysurgery.org](http://www.ambulatorysurgery.org). At our website there is a literature database, an international book, results of the international surveys, and also an international terminology. As part of our work we arrange education (e.g. International course Venice 2006) and if asked we are happy to give advising for professionals and authorities. As already mentioned we produce guidelines / clinical indicators and we nominate departments of excellence (for education/demonstration). If possible we have cooperation with other institutions – (WHO/ EU), and one result of this is the Policy Brief produced together with "European Observatory on Health Systems and Policies". Now we are working on a European Day Surgery Data Project.

In order to move for a change in direction of transformation against day surgery, it is important to involve both anaesthetists, surgeons, patients, and decision makers. And we will like to help with this in any country that is asking for our assistance.

In order to move forward There is a need for a shift of Paradigm: Day surgery is the standard procedure – any inpatient admittance must be argued !

Look for it at our next congresses in Brisbane and Copenhagen.

Claus Toftgaard, President, IAAS.