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Political round table – 'Breaking Down the Barriers'

Session Co-Chairs: Professor Dominique Jolly (France; Director of International Affairs, National Assistance, Hospitals of Paris) and Professor K Schutyser (Belgium; General Secretary, Hospital Committee of the European Community)

Professor Jolly welcomed delegates and panellists to this important discussion, the aim of which was to explore the attitudes of senior representatives of governmental bodies from throughout Europe to the development of day surgery.

The 'barriers' referred to are, of course, those obstacles that continue to delay the implementation of ambulatory surgery in the face of strong arguments based both on cost and quality. Professor Jolly explained that each panellist would be asked to address briefly the following two questions posed by Dr Claude De Lathouwer (Chairman, Congress Executive Committee):

- What political and organizational measures should be taken to ensure that a nation benefits from the fact that day surgery costs less than traditional hospital-based care?
- Assuming that an effective solution to the first question can be found, what incentives are necessary to encourage hospital doctors and consumers to adapt to a new system of hospital care?

Finally, Professor Jolly requested that panellists consider a question from Mr Paul Jarrett (Director of Surgical Services, Kingston Hospital, UK) who queries what, after full discussion between government politicians and decision-makers resulting in positive reports of day surgery, will really be done to put in place the necessary infrastructure for the rapid development of day surgery.

Belgium

The first question was addressed by the opening panellist, Mr Daniel Van Daele (Secretary General, Department of Health and Social Affairs, Brussels), who pointed out that the first priority should be the use of the best possible techniques rather than cost-cutting. Standards must be maintained in the face of rapid increases in the costs of healthcare.

In Belgium, the infrastructure has not yet been created for the development of day surgery, but some developments have been made. Pilot studies have been facilitated by subsidy from the Belgian Ministry of Health, and the National Council of Hospitals has also focused on this topic to produce guidelines. Mr Van Daele stressed that the development of day surgery is dependent not only on the Public Health Department, but also on the insurance system.

In Belgium, day surgery is currently practised at three levels. Some active day facilities are physically (but not legally) separate from the main hospital unit. In other institutions, separate areas or floors of the facility are set aside for day surgery. The remainder practise day surgery, nominally or actually, within the main hospital.

Mr Van Daele supported a flexible approach to the development of day surgery rather than creating strict regulations that may be worse than no rules at all. Saving money is important, but quality of care is paramount. He also pointed to hidden costs of day surgery when looking at the overall hospital budget. There also remain patients, particularly in the older generation, who require overnight stay.

In conclusion, Mr Van Daele remains unconvinced regarding overall cost-saving issues in day surgery. Rather, he supports the other arguments for the use of this form of treatment over conventional hospital stay, namely comfort, convenience and psychological benefits to the patient.

Mr Chris Decoster (Director General, Department of Health and Social Affairs, Brussels) then answered the second question from the Belgian viewpoint.

For the purposes of reimbursement, recent changes in legislation mean that day surgery facilities now have hospital status. This removes the element of risk for those hospitals wishing to practise day surgery. The Ministry supports a positive approach to stimulate the practice of day surgery. In the short term it is hoped to increase the activity of existing day facilities, and in the medium term (1994–1996) there will be a development plan whereby hospitals will receive incentives for performing, on a day basis, those procedures in which they already specialize. By 1997, the ministry intends to have

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in place the regulatory structures enabling day facilities to be treated in the same way as traditional facilities.

It is also important to encourage the medical staff, because it is they who will be overseeing these changes. This will require education to point out the benefits of day surgery. Education of the patient should also not be forgotten.

Chairman: The Chairman thanked the Belgian representatives. In recognizing that cost-benefits are not perceived by the Belgian authorities, he stressed that the important factor is that costs do not go up. Nevertheless, the fact that Belgian politicians are putting in place the statutory and financial environment for day surgery to develop is to be congratulated.

Portugal

Mr José-Luis Gil (Assistant Director General, Ministry of Health, Direction of Hospitals, Lisbon) stressed that it is necessary to have a hospital policy with the objective of creating alternatives to traditional treatment in response to the changing social environment.

The structures and resources must be made available for ambulatory surgery centres. Genuine integration between the hospital and public health is necessary to guarantee high levels of acceptance, and this can only be achieved through information, e.g. education of the citizen, and through the availability of an adequate aftercare home service.

Through substitution, such alternatives to conventional care will lead to a reduction in total numbers of hospital beds and incentives must therefore be made available to both individual and institution to encourage these developments. Social and environmental aspects must also be considered, for example, transport systems and education. The goal must be to promote a new organizational and management culture in the health system and in individual units.

The physical and organizational structures must be developed to increase the capacity at ambulatory level according to the concepts of 'diagnosis', 'centre' and 'non-invasive therapy'. Implementation and diversification are interconnected with the existing system and capacity concerning the so-called 'technical plateaux'. Changes must relate to the need of the patient and the mission of the institution.

In response to the question raised by Mr Jarrett, Mr Gil firmly believes that real change will only happen with the will of both central governmental bodies and those health professionals affected by such change.

Chairman: The Chairman highlighted the question of substitution raised by Mr Gil as an issue of considerable concern among surgeons and a major cause of the resistance to be overcome.

Sweden

Mr Andes Kaarik (County Council Commissioner, Department of Health and Medical Care, Stockholm County Council) explained that, in Sweden, different regional systems have replaced a uniform system, and each region has its own experimental systems. The system is paid for through county councils, and funding of healthcare is based on local taxation.

As in many countries, Sweden has tried to solve the major problems of rising cost and extended waiting lists. This has been attempted by restructuring in the Stockholm region to form nine districts with a central controlling body. One result has been a much improved general practitioner system. Hospitals behave as independent units and are reimbursed with prospective payments. Early results indicate increased productivity, particularly in ambulatory surgery, and almost all waiting lists have receded to less than 3 months.

Under the previous system, cost evaluation was very difficult, and more statistics are required to fully assess cost benefits of different health care options, particularly for ambulatory surgery; national statistics are useful and data on practice across Europe would be even better. In the new system, hospitals and clinics will compete for best results, and new ambulatory facilities will enhance competition.

With regard to incentives, pressures are required for any system to change. In this case, a precondition for change is a strong purchaser to exert profound economic and administrative pressures. For example, in the Stockholm model, this is the district authority.

Ultimately, the development of ambulatory surgery will rely on the use of the stick (e.g. reimbursement penalties) and the carrot (improved economic margins for outpatient procedures).

Ireland

A progressive attitude on the part of the Irish government was described by Dr Niall Tierney (Chief Medical Officer, Department of Health). He encouraged day surgery simply because it is good medical practice and a rational development of hospital medicine. His vision of the hospital of the future involves intensive treatment of a few patients and a large majority of patients being treated on a day basis or one-night basis.

The Irish politicians have already been persuaded of the cost benefits of ambulatory surgery. He quoted an increase in volume of day case surgery from 50 000 patients in 1985 to 134 000 per annum at present with a consequent reduction of 2500 beds. Some 20–25% of procedures are performed on a day basis, but there remains considerable scope for improvement.

In response to the first question, Dr Tierney does not perceive obstacles to day surgery, and there is no financial loss to professionals when switching to this form of treatment. Age is a consideration; young surgeons are more willing to perform day surgery than are their older colleagues. Recent advances in technology has done much to strengthen arguments for day surgery.

The question of incentives should be addressed both for patient and health professional. For the patient, education, information and persuasion are important.

However, the case in support of day surgery is clear and straightforward to convey. There are incentives for departments, who increasingly have budgetary control and will be able to retain savings achieved through practice of day surgery. It is important that day surgery experience is incorporated in medical training.

The statistics to support changes to delivery are currently poor, but as in Sweden, such information is now being retrieved to determine future policy.

In conclusion, Dr Tierney expressed the Department's unequivocal support for ambulatory surgery.

Chairman: The Chairman congratulated the Irish government on their clear policy in support of day surgery.

France

Dr A L'Hostis (Councillor, Ministry of Health and Human Affairs, Paris) looked at the following four major obstacles to day surgery in France:

- regulatory barriers;
- financial barriers;
- resistance within the health system;
- resistance from the patient.

Until changes in the French health law were introduced in 1991 and 1992, the regulatory and financial barriers to day surgery were overwhelming. However, changes in the reimbursement system have created the possibility of substitution and restructuring. However, the new tariffs that have been instituted apply only to the private sector. The question therefore of what developments can be made in the public system is still an open one.

Dr L'Hostis explained that resistance in the health system to change to day surgery stems from the fact that ambulatory surgery is a demanding discipline requiring considerable organization and rigorous selection criteria for patients. Motivation of health professionals will therefore require education and training. This applies not only to hospital staff but also to General Practitioners who discuss with patients the options for conventional or day treatments and are also important in follow-up.

Patients still show reticence regarding ambulatory surgery, in spite of studies demonstrating greater satisfaction of patients treated on an ambulatory rather than conventional basis. She emphasized that winning over patients will require good education and quality of at-home follow-up service.

Chairman: The Chairman pointed out the irony of a socialist government providing incentives solely to the private sector (about 30% of French hospitals).

The Netherlands

Professor A Van Montfort (Managing Director, National Hospital Institute, Utrecht) outlined two contrasting aspects of government policy. First, there has been a desire for all parties involved in healthcare to become more market-oriented, for example, in competing for funds. Second, overall government spending has come under greater constraints. Now, there is greater competition for scarcer resources. Simultaneously, there has been a considerable increase in demand for treatment.

In response, the government has withdrawn requirements for uniform standards in day surgery. Doctors and hospitals now have responsibility for the development of day surgery and decide the extent of substitution of day beds for inpatient beds. This form of internal substitution has ensured that day facilities have emerged within hospitals rather than as 'stand alone' facilities. The government has therefore encouraged self-regulation in the growth of ambulatory surgery.

Professor Van Montfort does perceive some resistance in the medical profession and attributes this to conservatism: the way that a doctor is trained will determine the way in which he chooses to practice.

United Kingdom

Mr Mike Cummins (Administrator, Department of Health, London) pointed out that at the political level of central government in the UK, there are no obstacles to day surgery. Since 1979, the number of day case patients treated annually has nearly trebled, from 570 000 to 1.5 million in 1991–1992. Surgical day cases had in fact increased from 383 000 to 1 100 000 in the same time period. Nevertheless, there is still considerable potential for growth.

In 1990, the Audit Commission reported in *A Short Cut to Better Services* the major differences in provision of day surgery between districts. A follow-up report in 1992 outlined interim progress but still stated that 14% of districts had no dedicated day facilities.

In 1985, the Royal College of Surgeons recognized the increasing importance of this form of treatment and issued guidelines for day surgery. A target of 50% was set as the desirable proportion of elective procedures to be performed on a day basis. Approval by this senior professional body bodes well for further growth.

The Value for Money Unit of the Department of Health examined aspects of cost, organization and implementation in 1991. The potential saving, hypothesizing a doubling of day care (to 30%), would be £124 million nationally. An alternative approach would be to plough back these savings so that a greater number of patients could be treated, i.e. a reduction in unit cost but no overall saving. Mr Cummins envisages reality falling between these alternatives.

The Department of Health have found the following to be the main obstacles to growth of day surgery:

- lack of enthusiasm in some health professionals;
- lack of enthusiasm from senior managers unwilling to change working practices and invest for the future;

- unsuitability of premises and costs incurred in modifying buildings;
- lack of systems and organization
- competition for funds due to treating more patients.

The solutions lie in improvements in supply of information and in support from government. Health professionals and managers need to have information to gain the confidence to make changes. The government has so far assisted by improving information flow and providing a good environment for growth of day surgery. Central funding has also been made available; in 1992 the Department of Health provided £15 million for the expansion of dedicated day units, and this was matched by Regional Health Authorities to provide a total of £30 million. This funding was again made available in 1993.

Mr Cummins briefly described the joint Department of Health/National Health Service 'Task Force' which has examined targets in day surgery (the 50% goal was reaffirmed), procedure and specialty targets and quality issues.

Recent health reforms have achieved an internal market within the National Health Service, which will further encourage growth as it will be responsive to cost-effective approaches.

The Annual CBO Conference on Day-Care

The Netherlands

26 November 1993

The Dutch organization for Quality Assurance in hospitals (CBO) has organized its third conference on day-care in hospitals.

The conference aims to reflect the "ins and outs" of day-care in the Netherlands and Belgium. The conference language will be Dutch. Themes for the plenary session will be key success factors for day-care and quality management in day-care. There will be parallel sessions for physicians, nurses and management and multi-disciplinary groups. In order to improve the exchange of information, all participating hospitals will be asked to make a poster presentation of the day-care unit in their hospital. The conference closing session is a consensus meeting on day-care.

The conference will interest all those involved in day-care in hospitals (professionals, managers, education, etc).

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