Ambulatory Surgery 1993; **1**: 154–157

Obstacles to the development of day surgery practice in Belgium

R van den Oever, B Hepp

National Alliance of Christian Benefit Societies, Brussels, Belgium

Ambulatory surgery interventions can be carried out in most Belgian hospitals without major side effects and to the satisfaction of the doctor, the patient and his socioprofessional environment and the health care insurers. However, the development of day surgery practice is severely hampered by the absence of a specific one-day clinic policy with clearcut guidelines and financial incentives for the hospital administrator, the doctor and the health care insurer. Ambulatory treatment is actually promoted by stimuli adapted to the individual hospital and directed to occupation rate, staff and organization. The budget savings obtained from a reduction in hospital admission days will be shared between the hospital and health insurance companies.

Key words: Ambulatory surgery, one-day clinic, health policy, health care financing

Introduction

Surgical and medical ambulatory treatment in hospital facilities has become increasingly popular among hospital administrators, doctors and patients. Since the introduction in 1982 of a yearly fixed quota of hospital admission days, every institution confronted with a growing number of inpatients seeks to reduce the mean length of stay in order to increase its total admission capacity. Together with a progressively closed-budget financing per diagnostic category for the total treatment regardless of the individual duration of the admission, the hospital becomes more dependent on the total pathology profile and the turnover rate of its patients.

The progress of medical technology in anaesthesiology, endoscopic and imaging techniques has enabled the doctor to carry out safely a growing number of diagnostic and therapeutic procedures safely on an ambulatory basis. In the one-day clinic structure the surgeon has both increased his patient capacity and has improved his treatment planning. For the patient and his immediate environment ambulatory treatment in the hospital combines the advantages of a quality-assured medical procedure with avoiding the inconvenience of overnight stay, repeated visits by relatives and a longer period of interruption of his/her professional activities. Finally, not only the employer but also the health care insurer is saving money by ambulatory treatment.

If all parties are interested in the promotion of the one-day clinic, what causes the considerable differences between various hospitals in adequate use of diagnostic and therapeutic means, and in the proportion of ambulatory and incare treatment for the same medical conditions? The investigation of historical, organizational and financial reasons actually limiting the development of day surgery practice in Belgium has helped the authorities in adjusting health policy on ambulatory treatment.

Day surgery practice in Belgium

In 1993 ambulatory treatment has become common practice for medical and diagnostic procedures such as endoscopy, biopsy, invasive imaging and chemotherapy. In one-day clinics general surgical procedures (e.g. skin lesions), oral surgery, ear-nose-throat, orthopaedic, ophthalmologic, urologic, gynaecologic and plastic surgery are most frequent. In Table 1 the evolution since 1986 of some in- vs. outpatient-based frequent surgical interventions in Belgium is shown. Even if ambulatory surgery increases in general, the one-day clinic share of routine procedures such as inguinal herniorraphy, arthroscopic meniscectomy and amygdalectomy is still disappointingly small.

In a small country like Belgium with a large number of hospitals (210) for a population of 10 million, day surgery facilities are hospital-based (for selective procedures three free-standing ophthalmologic day surgery clinics are privately owned and operate autonomously) and of two different types. The first type of hospital-based faci-

Accepted: July 1993
Correspondence and reprint requests to: R van den Oever, National Alliance of Christian Benefit Societies, Wetstraat 121, B1040 Brussels, Belgium.

© 1993 Butterworth-Heinemann Ltd
0966-6532/93/030154-04

Table 1. Evolution of some in- vs. outpatient-based surgical interventions in Belgium

		1986	*1987*	*1988*	*1989*	*1990*	*1991*	*1992*
Adenoidectomy	in	9584	8351	9048	8921	8482	8230	9401
	out	11 444	12 222	14 590	16 647	15 482	17 841	19 974
Amygdalectomy	in	13 362	13 642	13 674	14 425	15 783	16 687	18 543
	out	4892	5585	5994	6310	6308	6947	7519
Uterus curettage	in	35 020	35 480	32 027	31 485	29 993	29 097	26 564
	out	10 816	12 112	13 222	15 958	17 391	20 534	21 135
Arthoscopic meniscectomy	in	11 443	15 360	15 897	16 327	17 944	21 419	21 310
	out	470	715	1128	1850	2369	3465	4506
Circumcision	in	8636	8376	7954	8000	7821	7579	7250
	out	1870	2779	3174	3851	4699	5571	6319
Vasectomy	in	3028	2416	1826	2023	1793	2089	1723
	out	15 479	15 224	14 271	14 856	14 920	15 237	15 076
Inguinal herniorraphy	in	26 184	27 766	26 392	25 427	26 174	26 695	26 948
	out	179	202	228	497	643	865	1070
		152 407	160 230	159 425	166 577	169 802	182 256	187 338

Table 2. Evolution of day care practice in Belgium based on the number of forfeitary nursing-cost reimbursements*

Nursing-forfeit†	*1987*	*1990*	*1992*
Mini	24 663	37 307	45 000
Maxi	134 734	220 999	250 107
Super	36 789	74 609	85 040

* < 40% are minor surgical procedures.
†The forfeitary sum is due per procedure accepted for one-day clinic reimbursement and is approximately 30% (mini), 60% (maxi) or 120% (super) of the per diem price for each hospital, individually determined and based on overhead expenses, hotel and nursing costs and medical activity profile.

lity is integrated in the institution and either shares operating theatres, equipment, staff and infrastructure with the hospital or has to a greater or lesser extent its own facilities. The second type of hospital-based facility is self-contained and sited on the campus of the institution or, exceptionally, as a free satellite at a limited distance from the hospital.

For medical and for budget-saving reasons the satellite version of one-day clinics is excluded by the National Council of Hospital Affairs at the Ministry of Health (1992), that defined the one-day clinic locally and functionally to be a part of the hospital for planned medico-specialist procedures within the pluridisciplinary framework of hospital activity. After the introduction of yearly quotum hospitalization days for every hospital to treat inpatients, the policymakers considered the overhead expenses of the one-day clinic covered, and decided in 1986 to pay for ambulatory surgery only by fee for service, together with a percentage of the individual hospitalization day price for personnel costs. So only for a limited list of surgical interventions can the hospital charge a small (mini), medium (maxi) or large (super) forfeitary sum to cover its hotel costs according to the size and complexity of the ambulatory care provision.

In Table 2 the evolution of total day-care practice in Belgian hospitals is shown, based on the number of these forfeitary nursing cost reimbursements by health insurance companies. Less than 40% of these numbers concern surgical procedures, with the majority being smaller interventions (skin lesions, orodental surgery); the rest covers medical and diagnostic procedures (endoscopy, imaging) carried out in the one-day clinic. So the physician has, since 1986, as a result of economic considerations, preferred ambulatory procedures for transtympanal ear drum, gingivectomy and surgical tooth extractions among the provisions with a small forfeitary sum, for cystoscopy, vasectomy and adenoidectomy among the provisions with an intermediate forfeitary sum, and for curettage, colonoscopy and circumcision, among the list of provisions with a high forfeitary price. But on the contrary varicectomy of the lower limb or strabismus correction (intermediate sum) and lens extraction or herniorraphy (high forfeitary sum) are rarely carried out in day surgery, because the working costs are not completely covered.

This method of financing ambulatory surgery – a fee for service for the procedure that is the same for in- or outpatient treatment plus a percentage of the hospitals' day price – did not give administrators or physicians an incentive to develop one-day clinic activities.

Major obstacles to day surgery development

Since there is not perfect accord between the real costs of some surgical procedures done on an outpatient basis and the forfeitary day price compensation, the hospital is not fully rewarded for this activity and will oppose most one-day clinic initiatives by the surgeon. Only hospitals that are faced with insufficient bed capacity and waiting lists for inpatient treatment, have developed ambulatory care spontaneously. This results in high percentages of day care treatment in some hospitals and the complete absence of ambulatory treatment in others for the same procedures, a phenomenon indicated previously by Morgan and Beech[2]. At the same time hospitals with excess bed capacity and no day clinic experience are against a supplementary fee for service financing of ambulatory treatment because they might indeed lose patients who will seek ambulatory care elsewhere.

The hospital that actually does start a one-day clinic will be penalized, since the mean length of stay of its remaining inpatient case mix will increase and the hospital therefore takes the risk of day quota reduction and even bed reduction by the Ministry of Health. The institution is not compensated for the increased severity of the same diagnosis-related group (DRG) population needing incare treatment, and the ambulatory activity is not calculated within the total hospital profile, that will partially determine the per diem price (nursing cost and hotel cost). The combination of these elements has led to a negative selection of minor procedures (especially diagnostic) that are sufficiently covered by forfeitary payment and doctor's fee, but can be easily carried out in any ordinary doctor's office.

The physician in his turn is also less inclined to expand his ambulatory surgery activities. The absence of guidelines and of a legal basis for day care activity creates a liability risk and an atmosphere of misunderstanding with the patient, the family physician and the health insurer. Expansion of hospital-based activity by the one-day clinic surgeon to extramural ambulatory care, pre- and postoperatively, is not well understood and thus not accepted by the family physician and the other primary care workers, who consider this to be unfair competition in their sphere of activity. Without any financial compensation for his investments in training and infrastructure, and for his extra work in ambulatory treatment organization, the surgeon, fearing the reaction of non-referral by the general physician, has no reason to develop one-day clinic activity against the interests of his hospital administrator.

The possible savings of ambulatory care in this country are not a specific objective for the health care insurer. The lack of financial responsibility with the Belgian official compulsory health insurance companies does not stimulate their interest in day surgery development. The same goes for the majority of patients who are completely covered by third party payers and are fully compensated for sick leave and lost working hours. Ironically enough for the independent workers, who are attracted by one-day clinic treatment, compulsory health insurance for them does not include ambulatory care. Moreover, the health insurer and the patient are not informed by the doctor or the hospital about the possibilities and advantages of ambulatory treatment, since the latter do not benefit from day surgery development under the present circumstances.

Stimulating day surgery development

In order to elaborate a health care policy on ambulatory care the Minister of Health and Social Affairs conducted a pilot study and evaluated the activity of eight one-day clinics during 1990–1991. The final report of this study confirms the results previously published and concludes that ambulatory surgery is safe when organized in a functional relationship with the hospital, is appreciated by the patient, and can produce considerable cost savings. It concerned the data of 11 955 patients (45% between 15 and 44, 21% between 45 and 59 and 19% between 60 and 74 years of age) living at a mean distance of 3–10 km from the one-day clinic. Only 91 patients had to stay overnight for medical reasons.

Table 3. Mean reimbursement (in 000s BFrs) for inguinal herniorraphy in seven hospital categories inpatient vs. ambulatory treatment (Belgium, 1989)

Hospital category (number of beds)	*Procedures*	*Mean reimbursement*
I. <150	926	37.4
II. 150–249	1804	40.5
III. 250–449	2704	40.1
IV. 450–599	730	41.4
V. ⩾600	378	45.5
VI. Teaching hospital	387	62.5
Ambulatory*	130	15.8

*Procedures in one-day surgery centre.

The important potential for cost savings by ambulatory surgery is clearly demonstrated by the mean reimbursement amounts for inguinal herniorraphy[4]. The mean health insurance costs of herniorraphy increase with the size of the hospital from 37 400 to 62 500 BFrs for inpatients against 15 800 BFrs mean reimbursement for ambulatory treatment (Table 3). These important differences in total reimbursed amount for the same procedure on a comparable patient are partially due to the higher per diem price of larger hospitals, but can also be explained by the use of more laboratory tests, medical imaging and drugs, in proportion to hospital size.

During 1992 the National Council for Hospital Affairs of the Ministry of Health accepted a set of rules for the accreditation and functioning of ambulatory care centres. So the legal framework for one-day clinics can be build and an answer can be given to problems concerning structure, process, responsibility and liability. In the development of day surgery the health authorities and the social health insurance companies follow different options. The first prefer accreditation of one-day clinics and financing by subsidization (infrastructure) plus an adjusted individual per diem price (working costs) for each hospital. The health insurers want to avoid overregulation and propose financing ambulatory care by combined remuneration of the doctor (fee for service) and of the family physician (post care) together with a uniform compensation for nursing cost regardless of the type or size of the institution. Only because the hospital is not actually completely compensated for all costs of ambulatory treatment and for the proportionally heavier inpatient case mix, is there no need to subsidize and finance the construction and functioning of a one-day clinic in every hospital in Belgium.

Most hospitals have enough facilities and infrastructure to continue and develop ambulatory treatment, but they have to be compensated according to the real costs. This means payment for working costs of the one-day clinic and compensatory payment of severity-adjusted DRG's for hospitalized inpatients. Also the ambulatory activity of the hospital should be calculated in the total

hospital profile with adjustments for the mean length of stay of incare patients. On the other hand a reduction in bed capacity and inpatient day-quota has to be imposed upon the hospital with insufficient occupation rates and excessive lengths of stay, that deliberately does not develop ambulatory treatment for minor routine surgical procedures.

For the doctor a specific fee is proposed to cover his extra costs of investment in skill and organization in performing diagnostic and therapeutic procedures on an ambulatory basis. Special attention has to be given to prevent lucrative selection and hazardous practice in the one-day clinic by medically sound guidelines, quality assessment and correct financing of inpatient cost.

Only by creating a minimum financial responsibility for the health insurer, will the latter be interested in the possible budget savings of day surgery. In order to employ the means of modern medicine and anaesthesiology the insurer can stimulate preferred ambulatory care by increased reimbursement rates.

The report in 1993 by the Minister of Health and Social Affairs accepted experiment that was integrated into the framework of the negotiated national agreement between hospitals and health insurers, provides an example of such preferential reimbursement policy[5]. In this experiment for a selected number of surgical procedures that are frequently carried out on an ambulatory basis in some hospitals, but always seem to need admission for several days in others, the hospital administrator can charge two to five times a forfeitary pro diem price when the intervention is done in day surgery. This multiplied day price is calculated upon the mean length of stay for the same procedures, when carried out with hospital admission. So the ambulatory inguinal herniorraphy entitles the hospital to charge five forfeitary pro diem prices to the insurer, because the mean duration of admission in 1992 for this procedure was five days. The mean total reimbursement for inguinal herniorraphy in the one-day clinic will thus be comparable with the reimbursement in the above-mentioned first hospital category (Table 3). It will soon become clear how many of the selected procedures (see Table 1) will have been shifted from the inpatient to the outpatient list and from one institution (unable or unwilling to provide ambulatory surgery) to another.

Until now it has not yet been clearly established how the patient himself can be optimally motivated to choose the one-day clinic. Probably a policy of complete and sustained information about the advantages of ambulatory surgery, directed at the patient, his immediate environment and his family physician might be a good start.

References

1 Criteria voor het chirurgisch Dagziekenhuis. Advies van de National Raad voor de Ziekenhuisvoorzieningen. Ministerie van Volksgezondheid, 1992

2 Morgan M, Beech R. Variation in length of stay and rates of day case surgery: implications for the efficiency of surgical management. *J Epidemiol Community Health* 1990; **44**: 90

3 Piloot project Dagziekenhuis 1990–1991. Ministerie van Volksgezondheid, Rijksadministratief Centrum, Brussels, 1992

4 Rutten P, Ledecq M, Hoebeke Y, Roeland A, van den Oever R, Croes L. Hernie inguinale primaire; hernioplastie ambulatoire selon Lichtenstein: premiers résultats cliniques et implications économiques. *Acta Chir Belg* 1992; **92**: 168–71

5 van den Oever R. Daghospitalisatie. Voorstel van experiment binnen de nationale overeenkomst verpleeginrichtingen-ziekenfondsen. *Het Belgisch Ziekenhuis* 1992; **211**: 23–5