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Types of ambulatory surgery centres and how to initiate them: Canadian system

The chronic financial deficit of Canadian hospitals has forced the closure of inpatient beds mainly at the expense of departments of surgery. One-day surgery has been shown to be a safe and satisfactory alternative to inpatient care for several surgical procedures, although studies do not demonstrate major cost savings. One of the few randomized clinical trials performed in Canada[1] has shown that tubal ligation and hernia repair were cost efficient and averaged hospital savings of $86.00 and $115.00 more than inpatient care. However, meniscectomy deviated from this trend in that treatment costs were significantly higher for one-day surgery patients. Moreover a significantly higher proportion of one-day patients than their hospitalized counterparts found their stay to be too short and would prefer hospitalization as an alternative. As advances in technology and in surgical and anaesthetic expertise allow more complex procedures to be performed in an outpatient setting, the aging of the population might prevent the evolution of this approach. Moreover, the sophistication of new technology has increased the price of instrumentation to a level which prevents public hospitals affording them. In the Canadian system, we cannot yet pass this new burden to the patients.

The volume of day surgery in the Province of Quebec has been growing at the rate of 3–4% annually, since 1984. By 1989, day surgery accounted for less than 30% of surgical procedures in Quebec[2] and for 42% in British Columbia[3]. There is now more governmental pressure to increase the numbers of outpatient procedures.

In Canada, facilities used for outpatient surgery are mainly hospital-integrated units. Usually the attending surgeon mixes some day-surgery cases with his inpatient elective surgery cases. Such units are more prone to operative delays and cancellations when major procedures are prolonged or urgent procedures must be performed. To avoid these problems, new hospital surgical units independent from the inpatient surgical facilities are emerging. These units remain inside the hospital under the legal jurisdiction of the board of directors. Satellite units or free-standing units are still prohibited by the Canadian Hospital Act. Some specialists have tried to challenge that issue recently without success.

The list of procedures to be performed in these units remains vague. The American College of Surgeons opposes a definitive classification of operative procedures. Canadian surgeons also prefer to consider each case individually. In each hospital, there should be an agreement between surgeons and anaesthetists for acceptable procedures and patient risk factors. The ideal procedure should be short (less than 90 min) with a short postoperative recovery, with few anticipated postoperative complications and easily controlled postoperative pain. The patient should live within 50 km (30 miles) of the hospital and have help at home for the first 24 h.

Establishing a programme of outpatient surgery is a challenging task in the Canadian system[4]. Three main issues have to be settled:

1. Patient: As the patient has access to free services, he wants what he considers to be the best treatment and in-hospital recovery remains the standard with minimal burden on the family and the maximal feeling of security. Moreover certain insurance companies give better benefits for an inpatient procedure which is considered more 'serious'. However, as the waiting time for minor surgery has increased dramatically recently, some patients are now considering alternatives. Certain rules have to be changed and better education of the consumer has to be established.
2. Surgeon: As inpatient facilities are regularly reduced, the surgeon still wants to maintain good patient care and a short waiting list: two incentives for day surgery. The criteria for the selection of patients, although relatively clear in the literature, needs consideration by surgical judgement. Good support from the hospital facilities and a proper back-up system for the first 24 h, as well as the collaboration of consultants (cardiologists, pneumologists and endocrinologists) for preoperative evaluation, are required.
3. Hospital: With a chronic deficit and no hope of reducing costs, the establishment of day surgery needs new funding. The reallocation of funds and personnel is severely impaired by collective agreements and delays the settling of the new system.

Conclusion

In Canada, surgeons consider outpatient surgery as a very sensible way to solve certain problems but settling the issue will need political and societal choices.

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Serge Dubé
Associate Professor,
Department of Surgery,
University of Montreal,
Montreal, Quebec,
Canada

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