Presentation to the Standing Senate Committee on Social Affairs, Science & Technology

Canada's Health Care System
Senator Kirby, Chair

Ambulatory Surgical Centres in Canada

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Presented by
Dr. Mark Godley, Medical Director,
False Creek Surgical Centre

Background

The first free-standing ambulatory surgical centre (ASC) was established in the United States in 1970. The development of non-hospital based surgical centers grew to 459 facilities by 1986, and by 1999, to more than 2,700 ASCs performing over 6 million procedures annually[1].

In 1986, there were 459 ambulatory surgical centers in the US; by 1999, that number grew to over 2,700.

Advances in technology and improvement in anesthetic drugs lead to surgical procedures, otherwise requiring hospital care, being performed in non-hospital settings. Patients recovered faster from minimally invasive surgery and suffered less post operative side-effects.

Non-hospital based surgery has flourished in the United States. Now, federal and state controlled regulatory bodies govern the standards of practices for these facilities. Medicare (38 million Americans covered) and Medicaid (30 million Americans covered) contract out surgical services to hundreds of private ASCs.

The US HCFA estimates the following cost savings when a procedure is moved from an inpatient hospital setting:

53% when a procedure is performed in a hospital ambulatory

63% when a procedure is performed in a freestanding facility

73% when a procedure is performed in an office facility

Code of Federal Regulations, Title 42, part 416, "Requirements for participation in Medicare," explicitly states that any payment "must be substantially less than would have been paid under the program if the procedure had been performed on an inpatient basis in a hospital". In 1977 the Health Care Financial Administration (HCFA) of the United States studied the cost of care and noted a significant cost differentiation when procedures were provided in non-hospital surgical environments.

With few exceptions, Canadian Medicare has not embraced the delivery of surgical services outside the government controlled publicly administered hospital system. Provincial legislation enforcing the Canada Health Act, have, to date, prohibited the development of private freestanding ambulatory surgical centers. Consequently, Canadians faced with unacceptably long waiting lists for surgery have denied the freedom to choose this route as an alternative for surgical care.

Ambulatory Surgical Centres in Canada

The False Creek Surgical Centre (FCSC) was founded in 1999. At that time, due to the Federal Canada Health Act and the Provincial Medicare Protection Act, the Centre was only able to perform non-insured services (cosmetic surgery). This facility rapidly grew to become a multidisciplinary surgical facility treating Workers Compensation Board (WCB) patients as well as other peoples not deemed insurable under the Canada Health Act.

In June 2001 Surgical Spaces opened the Maples Surgical Centre (MSC) in Winnipeg. These two facilities represent the handful of ASCs that exist in Canada today. Others include the Cambie Surgery Centre in Vancouver, the Health Resource Group in Calgary, and the Shouldice Institute in Toronto.

At the very least, we can consider that ASCs have not yet been embraced by any level of government in Canada as a viable surgical delivery model. As a result, each province is left to interpret the Canada Health Act and determine their own guidelines for the establishment, regulation, and use of ASCs in Canada.

For example, Manitoba Health contracts out through regional boards, medically necessary procedures to private surgical facilities. By recent provincial legislation, these "contracts" are determined at the pleasure of the Minister of Health.

In British Columbia, contracting out of health services has occurred minimally at the regional health board level.

One such example is the contracting of cataract surgeries in North Vancouver. It is estimated this contract has decreased waitlists across the board for ophthalmic surgery.

Governance

Ambulatory surgical centres fall under the governance of the College of Physicians and Surgeons for each province. One of the goals of the College is to protect the public from potentially negligent care while at the same time, guide the physician in the quality of care they provide.

The accreditation of ASCs differs from province to province. For example, the scope of surgical services allowed in the non-hospital surgical facility has been increased in Alberta since that province allows overnight stays in these facilities. British Columbia has had overnight stay capabilities since March 1999. In Manitoba, overnight stays are not permitted in non-hospital surgical environments.

Compounding the issue of governance and regulation is the actual definition of a hospital. The Hospital Act (1996) of British Columbia defines a hospital as meaning:

a non-profit institution that has been designated as a hospital by the minister and is operated primarily for the reception and treatment of persons a) suffering from the acute phase of illness or disability; b) convalescing from or being rehabilitated after acute illness or injury; or c) requiring extended care at a higher level than that generally provided in a private hospital licensed under Part 2.

This definition varies from province to province. Further, it fails to address the role of ambulatory surgical centres within the context of hospitals and their governance.

The College of Physicians and Surgeons of British Columbia has a manual guiding the doctor on the requirement for a non-hospital surgical facility. In Ontario no accreditation process is in existence under that College's by-laws.

Ambulatory Surgical Centres: Statistical Data on False Creek Surgical Centre[2]

As a non-hospital ambulatory surgical facility, False Creek performs over 2000 surgeries annually, and 4193 since opening in 1999.

False Creek Surgery Centre: 1999 – present Data

WCB	1951
WCB Back Surgery	80
RCMP	35
Private cosmetic	1857
Private other	270
Colonoscopy	80*

**3 positive for colon cancer*

Of that, nearly half of all cases are for the Workers' Compensation Board (WCB) of BC. In addition to contributing to expedited return-to-work programs, FCSC has provided surgical services to private paying patients, including visitors to Canada.

During the past three years, 80 diagnostic colonoscopies have been conducted at the facility; three of which resulted in positive test results and a determination of cancer. Expedited diagnostics contributed to early intervention in the case of these three patients.

Still 45 percent of the surgeries performed at the Centre are private cosmetic procedures. As a free-standing ambulatory centre, FCSC provides a safe environment for such procedures.

Regional Breakdown of WCB cases (1999 – present):

Prince George:
3 surgeons - 367 cases

Kamloops:
1 surgeon - 157 cases

Vernon :
1 surgeon - 8 cases

In addition to providing operatory time for surgeons in Vancouver, FCSC contributes to keeping surgical specialists in their regions. Currently five rural surgeons have privileges at FCSC. Each month, these surgeons book blocks of time at FCSC, and patients and surgeons are flown to Vancouver for surgery.

Aside from providing much needed surgical time and allowing workers faster return to work, FCSC provides the additional benefit of retaining valuable, talented surgeons in Canada, and serving their regions.

In addition to surgeons, centres such as FCSC serve to retain valuable health service providers. This one centre currently employs three full-time nursing staff, as well as 57 part-time medical staff, 3 full-time and 7 part-time ancilliary staff. Year to date (September, 2001), this accounted for $102,535 in source deductions and contributions to federal taxes, pensions, and employment insurance.

Quality Management

An ongoing, comprehensive self-assessment of the quality of medical care being provided must be conducted by non-hospital surgical facilities with the active participation of medical staff.

Surgical Complication Data (FCSC 1999 to present):

Hospitalized post-op:
3 cases

Infections: 16 cases

Late hospitalization:

Hematuria	1
Pain control	1
Anemia	1

Since its inception, FCSC has monitored its surgical complication data through telephone follow-up with each patient. This data has concluded a 3 in 4193, or 0.07% hospitalization rate, an infection rate of 0.38%, and a late hospitalization rate of 0.07%.

Statistical evidence of this belongs with the public. False Creek Surgical Centre publishes this data on its website at www.nationalsurgery.com

In addition to collecting and managing this data, ASCs such as FCSC have a valuable role in the development of other health-related programs. Some examples of this include:

- Only screening colonoscopy program in British Columbia. Three case of malignancy detected.
- Only private surgical facility to be accredited by the Canadian Council for Health Services Accreditation.
- Residency training in Plastic surgery, and orthopedic surgery.
- Exclusive contract with WCB to perform expedited back surgery.

Recommendations

1. Licensing of Ambulatory Surgical Centres

Licensing of Ambulatory Surgical Centres

Recognition of free-standing, private Ambulatory Surgical Centres as a valuable, viable alternatives to hospital-based ambulatory surgeries. This has proven cost-effective in the United States, demonstrating a cost savings of up to 63% over in-patient hospital based cases.

The implication of this across the Canadian health system is vast: it requires a clarification of the interpretation of the Canada Health Act as it relates to its founding principle of "publicly administered"; it requires agreement by provincial administrations as to the definition of "hospital" and "ambulatory surgical centres"; it requires the acceptance by provincial governments as to the ability of ASCs to service publicly insured patients.

2. Governance

Governance

One standard by which all ASCs comply is essential to the cost-effective operation of these centres. As demonstrated in this submission, the provincial Colleges of Physicians and Surgeons have yet to determine a standard for non-hospital surgical facilities. This requires the delegation of authority for governance of ASCs to each provincial College, and the responsiveness of each College to define the regulatory environment for ASCs.

3. Triple Bottom Line Accountability

Triple Bottom Line Accountability

We propose that triple bottom line accountability in the provision of private health services will provide all stakeholders with confidence in the delivery of these services in a system operating in parallel to the existing publicly funded health system. Such accountability will ensure that the patient and their medical outcome are the centre-point of a parallel private system, focusing on holding the patient sovereign in the delivery of health services outside of the publicly funded system.

The triple bottom line will be measure by fiscal accountability, accessibility, and health status.

Fiscal Accountability

This implies that the private health provider is accountable to all stakeholder – payers, providers, patients, and shareholders – for the provision of financially responsible health services. As such, the delivery of health services in a market-driven model will see efficiency through competition. These are not "shortcuts", but rather focused delivery centres. Fiscal accountability will be measured by the value derived by stakeholders in the equation and the term "for-profit" will imply for the profitability of all stakeholders.

Accessibility

The ability of the private health provider to deliver patient-centered health services will be a cornerstone to the accountability equation. As such, access will be measured in terms of days, not months, and by the ability to deliver reduced time to specialist and subsequently, reduced time to surgery. Similar to how our private third party contracts are structured now, where we must guarantee access within 21 days, a parallel private system must be held accountable for patient accessibility.

Health Status

We believe that a parallel private health system can have a significant impact upon the health status of the population it serves. Specifically, looking at the 14 indicators of health status identified by the Provincial Health Ministers in the fall of 2000, we believe that a responsible parallel private health system can impact the following seven health status indicators:

- Changes in life expectancy
- Self-reported health
- Improved quality of life
- Reduced burden of disease and illness
- Waiting times
- Patient satisfaction
- Readmissions

Note: The remaining health indicators relate to public health issues, including life expectancy, infant mortality, low birth weight, access to 24-hour, 7-day a week first contact health services, home and community care services, adequacy of public health surveillance, adequacy of health protection/promotion

About the Presenter

Dr. Mark Godley is the Medical Director of both the False Creek Surgical Centre and the Maples Surgical Centre, and a partner in their management company, Surgical Spaces Inc.

South African born and trained, he moved to Saskatchewan where he practiced as a family doctor in a small community for two years. Following this, he attended both the University of Alberta and the University of British Columbia, graduating in 1995 as an Anesthesiologist. After graduating, he found that securing a permanent hospital position was difficult due to reduced operating times in the hospitals. He worked as a consultant Anesthetist at the Peace Arch Hospital until making plans in 1997 to open an ambulatory surgical centre, which became the False Creek Surgical Centre.

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[1] Conner, R. (Ed.) (2001). Ambulatory Surgery Principles and Practices. Denver, CO: AORN, Inc.

[2] This information is derived from data compiled by False Creek Surgical Centre. Patient satisfaction surveys are made public on the website www.nationalsurgery.com