

Organisational Problems in Short Hospital Stay What are the Actual Problems in Belgium ?

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In our all day anaesthesia practice we are very concerned to deliver the best anaesthesia care for our patients. We have to adapt our management to the increasing constraints in budgets and manpower as financial support for health is restricted in every part of the world. Efficient cost-effective patient care can be provided, based on scientific evidence and adapted to the conditions.

The aim of my survey is to examine some of the last modifications in the health care structure in Belgium.

The health care insurance budget is drawn up by the National Sickness and Invalidity Insurance Institute (NISII ; INAMI ; RIZIV) and the Federal Public Service Health fixes the budget of all hospitals. The Budgetary Control Commission of the NISII is required to submit report on the evolution of revenues and expenditures. Reforms were introduced to keep expenses within a given financial envelop (national hospital budget), bed conversion policy has resulted in a reduction in the number of hospital beds. The Royal Decision (AR, KB) on the 25th of April 2002 formulates changes in the hospital financing and budget. This budget essentially covers part of the investment costs, the hotel costs and the nursing costs. Data obtained from the Minimal Clinical Data Set and the grouping of all patients' days into "All Patients Refined Diagnosis Related Group" (APRDRGs) have been used to introduce the rules for 'justifies' beds and 'justifies' stays. An increasing number of surgical procedures must be performed on an ambulatory basis and same-day surgical cases increase as duration of hospitalisation has to be reduced. The anaesthesiologists will have to reconsider a new organisation, as preanaesthesia evaluation is considered a basic element of anaesthesia care. One goal is to define those patients who would benefit in having care in an inpatient setting or those who require more intensive medical evaluation or preparation prior to surgery. Preoperative clinical problems and short hospital stay are review in other parts of this issue. The practice of anaesthesia in Belgium is not regulated like in other countries as France. The only

official statements concerning anaesthesia are published in the Belgian nomenclature for health care defining the reimbursable services : Ch 12 § 3 and in the article 51 of the Code of Deontology (1). Recommendations on pre-anaesthetic evaluation of patients have been published by the Belgian Society of Anesthesia and Reanimation and the Belgian Professional Association of Specialists in Anesthesia and Reanimation in 1998 (5). Their first recommendation was : "Whatever the circumstances, the pre-anesthetic evaluation must first base itself on an anamnesis and a clinical evaluation". From that time and the publication of Roger France (14) in 1997 about cost-effectiveness of preoperative examinations, anaesthesiologists are working for the improvement of the preanesthesia assessment. The modification of the nomenclature for the reimbursement of the preoperative visit with an anaesthesiologist is still on the Minister's waiting list. The request was accepted only for patients scheduled in one day surgery, under general anaesthesia and if the consultation takes place 48 hours before surgery. The patient has also the right to receive all information concerning the procedure beforehand to be able to build his own judgment before consenting (8).

Anaesthesia teams are dependant on other providers to provide appropriate data to best judge who is an appropriate candidate for anaesthesia. This issue is becoming all the more difficult because the acuity of patients and complexity of procedures being managed on an outpatient or same day admission basis increases.

Disease specific algorithms appear in the literature as well as propositions for enhanced the preoperative assessment (7,10,11,12,13). The practice advisory for preanesthesia evaluation reported by the ASA task force in 2002 states that there is no support for routine testing (11). The decrease in unnecessary laboratory testing can result in signif-

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Table 1

	ASA I	ASA II	ASA III
		Always assess cardiovascular risk	
ECG	Routinely > 50y	> 50y or cardiovascular, renal, respiratory disease, or taking certain drugs (1).	
Chest X-ray	Not routinely	Acute or chronic respiratory disease, cardiovascular or renal disease.	
Full blood count	History of anaemia, Recent loss of blood	History of anaemia, Recent loss of blood, renal disease	
Haemostasis	<i>General anaesthesia</i> : Not routinely	<i>General anaesthesia</i> : Not routinely	<i>General anaesthesia</i> : Renal disease and medium or major surgery
	<i>Loco-regional anaesthesia</i> : Not routinely	<i>Loco-regional anaesthesia</i> : Renal or hepatic disease, alcoholism.	
Renal function, K	Routinely >60y	> 60y and if clinical indication (2)	
Random glucose	Routinely if obesity (BMI>30)	Obesity, diabetes, renal disease, hyperglycaemic drugs (including glucocorticoids)	
Urine analysis	Urogenital surgery or new hip prosthesis		

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(1) and (2) : <http://www.centredexpertise.fgov.be> (publications).

icant monetary saving. The Federal Centre for Expertise in Health Care, Belgium (KCE) published a report on the evaluation of preoperative risks in October 2004 (9). They again insist on a preoperative interview and a focused physical examination before any tests. Some practical guidelines are summarised in Table 1. Patients ASA I,II or III, more than 16 years old, scheduled for an elective surgery, except cardiac or thoracic surgery, are concerned.

The Society for Anaesthesia and Resuscitation of Belgium also helps prepare and publish guidelines to promote Good Clinical Practice. The Belgian standards for patients safety in anesthesia were published for the first time in 1989(6) and updated in 2002 (3). Belgian guidelines concerning drug induced alteration of coagulation and central neuraxial anesthesia have been published in 2000 (4) and Belgian guidelines and recommendations for safe practice in obstetric anesthesia in 2003 (2). Clinical guidelines are based on the best available evidence. Guidelines help healthcare professionals in their work, but they do not replace their knowledge and skills.

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