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Waiting for Health Care

The Issue

Canadians have become increasingly concerned about the length of time they may be asked to wait for certain services provided under provincial health care plans. Concerns have focused mainly on waits for orthopaedic surgeries (especially, hip and knee replacements), cataract surgeries and advanced diagnostics, such as MRI scans. There are also less severe, but still worrisome, wait times in some jurisdictions for certain cancer and cardiac surgeries.

The causes behind growing wait lists and longer wait times are hotly debated:

- Is it a lack of capacity (e.g. human and other resources) within the system?
- Is it the federal cut-backs of the mid-1990s that forced rationing of services and created a back-log of patients?
- Is it the result of the inefficient management of lists and resources by:
  - Doctors?
  - Hospitals?
  - Regional health authorities?
  - Provincial governments?

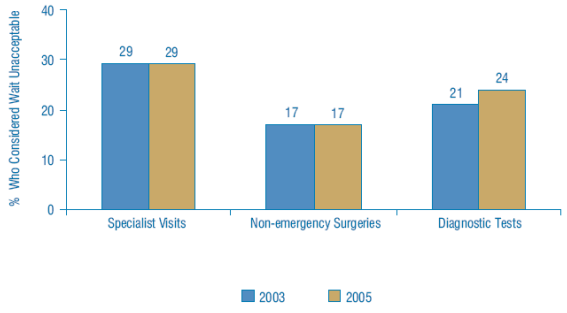
The simple answer to all these questions is "yes". Although no one factor explains why and how wait times have lengthened, some combination of them likely explains why a jurisdiction has a particular problem with a particular service.

Progress on Wait Times

The federal government increased its presence in the wait times issue at the 2004 First Ministers Conference, when it promised provincial governments targeted funds for wait time reduction strategies. The provinces had already been dealing with the issue for nearly a decade. Prompted by some initial studies by researchers and by media stories of egregious wait times suffered by some patients, provincial governments began serious efforts to understand the roots of growing wait times in the mid-1990s.

What Patients Say

Statistics Canada recently asked Canadians who waited for specialized services whether their waits were acceptable. Most said yes, as they had when a similar question was asked in 2003. Others did not consider their waits acceptable: 29% for waits for specialist visits for a new illness or condition, 24% for selected diagnostic tests (non-emergency MRIs, CT scans and angiographies) and 17% for non-emergency surgery other than dental surgery.



Source: Health Services Access Survey, Statistics Canada, 2003 and 2005 (first six months data).

These initial studies found that:

- There were multiple "lists" for the same service, managed by different actors in the system (e.g. doctors, hospitals, Regional Health Authorities and provincial governments);
- There was no standard definition of when a patient began waiting and thus no way to measure wait times. Did the patient's wait begin;
  - When they went to their family practitioner?
  - When they got their referral to a specialist?
  - When the specialist saw them and made a diagnosis?

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- When the specialist actually booked them for surgery or diagnostic tests?

Since the late 1990s, provinces have made incremental, but real, progress on wait times. Initiatives such as the Western Canada Wait List Project, the development of the Ontario Cardiac Care Network, web-based surgical registries in a number of provinces, and the development of scientifically rigorous benchmarks for particular kinds of services have all contributed to this progress.

Today, there appears to be a strong consensus amongst researchers, governments and stakeholders that;

- Wait lists need to be consolidated into single registries to be managed effectively;
- Patients need to be assessed using a common 'scorecard' to determine their severity of need and their placement on the list;
- Focused, incremental increases in resources in some parts of the system can have an impact on wait times;
- Reorganized processes for managing patient entry, treatment, and exit from surgical care can have more impact on wait times than unfocused increases in funding;
- Patients need access to transparent, understandable information that can help them make decisions regarding their care (e.g. that they might get faster treatment if they were willing to travel for surgery or have a different doctor perform it), and;
- Developing scientifically valid benchmarks are a priority in effectively managing lists. These would determine how long a patient with a particular severity of need should be asked to wait for a particular service in a particular jurisdiction.

The Future Challenges

- *Transferring Successful Models:* Progress has been both incremental and uneven across the country. Governments need to increase their capacity to learn from each other and adapt successful models across the country;
- *Realistic Goal Setting:* Successful "care guarantees" need to be based on achievable, realistic benchmarks, rooted in sound scientific evidence, if they are not to fail;
- *Health Human Resources:* Successful wait list management is intimately linked to the right mix of health professionals in each provincial health care system
- *Resisting "big-bang" Solutions:* Progress on wait lists must be made part of the larger process of primary health care reform and the integration of health and human services. Simple "fixes" tend to have unintended and negative consequences for other parts of the health system.

Further Reading

Cathy Fooks. 2004. *The Taming of the Queue – Wait Time Measurement, Monitoring and Management (Colloquium Report)*. Ottawa: CPRN.
Tom McIntosh. 2005. *The Taming of the Queue II – Wait Time Measurement, Monitoring and Management (Colloquium Report)*. Ottawa: CPRN.
Tom McIntosh. 2006. *Don't Panic: The Hitchhiker's Guide to Chaoulli, Wait Times and the Politics of Private Insurance*. Ottawa: CPRN.

Interested in discussing this work or collaborating in research in this or a related area?

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