Wait-Lists and Wait-Times

Wait-lists and wait-times are important issues to many British Columbians and figured prominently during the Conversation on Health. Some of the concerns raised included the demands placed on the health care system, equality of access to care, the negative effects that waiting can have on patients, and wait-list management. Here is a selection of what British Columbians had to say on the subject of wait-lists and wait-times.

Demand Management

Participants indicate that a universal health care system is a good model, but if it is to be sustainable, then it is important to find ways to manage the demands placed on it. Participants are concerned that public expectations are overburdening the health care system and go far beyond what was originally envisioned when Medicare was created. Others would like to see more accountability on how resources are used by health care providers and consumers, as well as more public education on the design, capacity and cost of the health care system. Participants, for the most part, agree that we need to inform the public about what the system is and what it can provide.

Participants talked about managing demand by defining the level of services that the health care system should provide. They offer a range of ideas on how to determine this, including: offering no extra care until everyone has basic health and dental care; setting a minimal level and anything over and above this level would be defined locally; setting priorities either by defining what is medically necessary; or, establishing a list of clinical priorities. While there is no consensus, most agree that in order to determine the level of services that the system should provide, Government needs a coordinated approach to health care planning that focuses on demand management, facilities management, and human resource management.

General Comments on Access

Throughout our consultations, there were many discussions on wait-list management, equality of access to care, and the effects that waiting can have on patients and their families. The majority of participants think that wait-lists are too long and are symptomatic of a problem with equality of access to care. They suggest that queue jumping occurs when patients seek private care or if they belong to special organizations such as the Insurance Corporation of British Columbia and WorkSafe BC. To address these concerns, most participants believe that Government needs to focus on providing a more responsive primary care system that is delivered in a holistic and integrated manner. Participants recommend: delivering health care services through alternate practice settings such as mobile or 24 hours a day and seven days a week clinics, finding ways to increase the number of primary care providers, and increasing the ways that we can access providers such as by phone, email, group visits and extended hours.

> *When you apply early intervention and address health concerns in a timely, holistic and coordinated manner, you reduce waitlists, better manage illness and achieve wellness faster.*
>
> - Health Professional Meeting, Prince George

Participants widely agree that long wait-lists lead to further health issues, chronic problems, and result in a poorer quality of life. To mitigate these effects, they suggest Government should find ways to offer care to waiting patients before their affliction becomes disabling or causes further damage.

Funding and Health Care Models

Participants want funding increases in areas that they see would have the greatest effect on improving wait-lists. Facilities, equipment and human resources were the most commonly suggested areas for funding increases. Others want funding to target rural communities in order to meet the needs and priorities of local populations.

Participants widely debated the role of the private sector in addressing the length of wait-lists. Some participants feel that a two tier system would exacerbate multiple wait-lists while others believe that we should use private clinics to shorten wait-lists. Some support a mixed model of public and private delivery to shorten wait-lists. A number of participants believe that discussions around delivery models and the public private mix should continue.

Administration of Wait-lists

Many participants voiced concerns on the efficiency and accountability of wait-list management, and others focused on the need for improved access to wait-list information. A number of participants are aware of the Provincial Surgical Services Project that tracks patients waiting for elective surgeries in British Columbia, but many participants either question the accuracy and comprehensiveness of this site or do not know that it existed. The Saskatchewan Surgical Care Network is highlighted as a good model of a comprehensive surgical database. Alberta is also recognized for its efforts to reduce wait-times for certain surgical procedures as it implemented a standardized referral tool and developed a single point of entry.

Many participants said that long wait-times for medical care and attention were unacceptable. To identify and track wait-times, participants argue for more accountability in the system, primarily by setting meaningful guarantees and benchmarks based on medical outcome evidence.

> *Establish a 'Health Access Fund' to enhance the portability of care for patients and their families by reimbursing the cost of care when services are not available provincially within the accepted wait time benchmark. This fund should be created to support patient care costs as part of the introduction of wait time benchmarks.*
>
> – British Columbia Medical Association, Submission

Innovation

Participants widely recommend that Government learn from and build on Canadian projects and international primary care systems that have successfully reduced wait-lists and wait-times. Participants cite examples such as the University of British Columbia's Centre for Surgical Innovation, the Richmond Hip and Knee Reconstruction Project, the Alberta Hip and Knee Replacement Project, the North Shore Joint Replacement Access Clinic, and Mount Saint Joseph Hospital's cataract and corneal transplant program. Participants also look to some international primary care systems such as the approach taken in New Zealand, which introduced clinical prioritization for elective surgery as a way to reduce wait-lists.

Conclusion

Over the course of the Conversation on Health, many participants advocated for a reduction in wait-lists and wait-times. They also voiced concerns related to the apparent queue jumping facilitated by private sector service provision or through other avenues of access to care, such as the Insurance Corporation of British Columbia and WorkSafe BC. Many participants also expressed a strong desire to reduce inefficiencies in the system and emphasized the value of taking a collaborative approach in meeting the health care needs of British Columbians such as sharing facilities, targeting funding, and learning from innovative projects and systems. Others emphasized increasing access to wait-list information, suggesting this would provide clarity to patients around their expectations and tools to Government and doctors for better management of wait-lists.

> *Wait times are really the result of a complex interplay between needs for care, the capacity and organization of services and public preferences and expectations. They are rarely simple, silver bullets, much as we might all like one. The answers tend to be multifaceted and implementation usually requires hard work and often difficult choices.*
>
> – International Symposium, Vancouver

Wait-Lists and Wait-Times

This chapter includes the following topics:

Wait-lists and Access to Health Care
Management and Administration of Wait-lists
Health Impacts of Wait-lists
Funding and Health Care Models
Innovation

Related Electronic Written Submissions

Four Initiatives for Health Care Change in BC
Submitted by the Cogentis Health Group

Is BC's Health Care System Sustainable?
Submitted by the Canadian Centre for Policy Alternatives

Physicians Speak Up
Submitted by the British Columbia Medical Association

Why Wait? Public Solutions to Cure Surgical Waitlists
Submitted by the Canadian Centre for Policy Alternatives

Sunshine Coast Conversations on Health
Submitted by the Women's Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group

Conversation on Health Submission
Submitted by The UBC College of Health Disciplines and The Interprofessional Network of BC

HEU Submission to the Conversation on Health
Submitted by the Hospital Employees Union

Report to the Conversation on Health
Submitted by the BC Cancer Agency

A Vision for Better Health
Submitted by the British Columbia Dental Association

Submission to the Conversation on Health
Submitted by the British Columbia Nurses' Union

Wait-lists and Access to Health Care

Comments and Concerns

Leadership and Structure of the Health Care System
Wait-lists and Access to Health Care
Wait-lists and Access to Health Care for Specific Populations

- Comments on leadership and structure of the health care system:
  - While there are a number of outstanding initiatives in British Columbia to reduce wait-times for elective surgeries, Provincial leadership has not appeared. Many of these projects exist in pockets of the system rather than throughout its entire fabric.
  - Long waits for hip and knee surgeries over the last few years reflects both a lack of resources and a lack of political will on the part of Government to pay for the work being done in a timely manner.
  - Long wait-times do not exist in isolation, but are symptomatic of deeply entrenched dysfunctions within the system. Drastically reducing and in some cases ending unreasonable wait-times requires transforming the system to put patients at the centre of the action.
  - Canada has one of the most expensive systems in the world, but one which delivers some of the worst wait-times and care when compared to other developed countries.
  - Lengthy wait-times for elective surgeries are at the core of many British Columbians' frustrations with public health care. Until public solutions are implemented province-wide, Medicare will not reach its true capacity to meet our health needs.
  - There is nothing wrong with our health care system right now. Long wait-times are propaganda from the media and people who are not critically ill. As a cardiac patient, I have always had reasonable wait-times.
  - Although close to 85 per cent of Canadians say they are very satisfied or somewhat satisfied with the overall way health care services are delivered, too many are anxious, frustrated and angered by untimely waits to see a specialist, get diagnostic tests or undergo elective surgery.

- The Conference Board of Canada reports that British Columbians register a high level of dissatisfaction with service delivery (especially hospital wait-times) even though the Conference Board ranks British Columbia's health care system first in Canada.
- Wait-times are the result of a complex interplay between needs for care, the capacity and organization of services as well as public preferences and expectations. There is no easy single answer. Answers tend to be multifaceted and implementation of them usually requires hard work often with difficult choices.
- To a significant degree, the health care system is asked to perform more surgeries simply because it is more capable than ever of relieving a patient's pain and suffering and increasing their quality of life. Of course, this is a good thing, but the effect of more people demanding more surgery is longer wait-lists.
- We do not pay enough attention to the signal problem in Canadian health care, which is more quality related then it is access. This does not mean that there are no access problems and we do need to address them, but quality is the bigger problem.
- Too often we cannot get care for a small health problem until it becomes a life or death situation, which costs significantly more money than the small problem would have cost.
- The management and reduction of wait-lists and times must not be limited to the five priority areas identified in 2004 by the First Ministers. Although these are important areas, it is critical that waits for other procedures or in other areas of the health care system not be ignored. Otherwise we will end up with the balloon effect, where focus on waits only in specific areas and actually increase waits in non-targeted areas.
- All technologies and services should be available immediately for the management of health. However, it is the wait-list that throttles the insatiable demand for these resources. In other jurisdictions, out of pocket expenses and Health Maintenance Organizations take care of throttling demand. Wait-lists work to solve this problem, but they are inefficient, as waiting for treatment can incur all sorts of tracked and hidden expenses on the health care system and society as a whole.

- Comments on wait-lists and access to health care:
  - Across a number of key areas, the British Columbia health care system is performing substantially more surgeries than it would from population growth or aging alone. Yet despite the increase in surgeries, wait-lists are still an issue because technology has increased demand as well as the number of people who can avail themselves of such surgeries.
  - Long wait-lists deny citizens prompt emergency attention.
  - People on wait-lists are basically held hostage by the medical system and cannot do anything. This is because they wait in eager expectation for the call to confirm their procedure, but the schedule keeps changing and the scheduled date keeps being pushed farther away.
  - Wait-lists have improved so critical patients can get what they need.
  - All you ever hear about in public discussions are wait-lists.
  - The sole determinants of a population's health is not, as many would suggest, the wait-lists for Medical Resonance Imaging (MRI) and joint arthroplasties.
  - I found out that I had an inguinal hernia but I was informed that there was a nine month wait-list. I did not want to wait so I went to the United Kingdom where I had the procedure in one week.
  - I am currently off work due to an injury and my insurance company will only pay for three months. During these three months I must see a specialist and submit a Magnetic Resonance Imaging (MRI) report. However, I have to wait five months to see the specialist and six months for Magnetic Resonance Imaging (MRI). I am now forced into making a choice to wait or pay for it privately.
  - There are wait-lists for elective surgeries but none for abortions.
  - Many people wait far too long for services, yet are denied the right to do anything about it.
  - There are no wait-lists if you are a Member of the Legislature, as you get immediate medical assistance. This is wrong.
  - Are there are any professional sports players or labour union members on a wait-list for procedures?

- There is too much queue jumping by people going to other countries to get surgical procedures done, or through affiliation with special groups such as Worker's Compensation Board, Department of National Defence, the RCMP and well placed individuals within the system.
- The serious problem of wait-lists means that accessibility to health services varies by problem area and by region. The principle of equal access is violated in practice every day in every province.
- There is a one year wait for most procedures, but if you are a nurse, laboratory technician or even just know someone in the hospital you can have the procedure much sooner.
- What consideration is given to people who are on medical wait-lists and are the sole providers for their families? For example, a self-employed businessman can be financially ruined by having to wait for a medical procedure, not to mention the aggravation of seeing their livelihood and business destroyed and not being physically able to do anything. The willpower is there but because of a medically necessary procedure that is wait-listed they cannot physically do anything.
- Access to health care is wonderful despite wait-times.
- Here is a sampling of the types of wait-lists that many consider too long:
    a. assessments and access to primary care;
    b. referral and access to specialists;
    c. surgeries such as joint replacements and cataracts;
    d. diagnostic procedures such as Cat Scans and Magnetic Resonance Imaging (MRI);
    e. care services such as home support, adult day care programs and day hospital programs;
    f. assisted living, residential care and extended care provisions for the disabled and elderly;
    g. assisted devices such as wheel chairs and walkers;
    h. beds, including respite, emergency and crisis from home;
    i. medical attention and treatment in emergency departments;
    j. mental health services and counselling; and for
    k. rehabilitation services.

- Comments on wait-lists and access to health care for specific populations:
  - The current system is not working for marginalized and rural communities such as the homeless, First Nations, rural, and so on.
  - Women have special needs for health care such as needing:
    a. to see a female doctor;
    b. to have medical procedures that are less intrusive;
    c. access to community-based alcohol and drug addiction treatment services;
    d. greater awareness surrounding post-partum depression;
    e. homeopathy to be covered and free prescription medications;
    f. access to unbiased information about pharmaceuticals;
    g. a women-only emergency shelter in the Downtown Eastside of Vancouver, British Columbia;
    h. more income and housing assistance;
    i. more hiring of First Nations women; and
    j. more education for doctors on violence against women.
- The current wait-time initiatives ignore children. For example, 65 per cent of children in this country are waiting a medically unacceptable period of time for health care.
- There is concern that elderly people waiting to have medical treatment or attention will have to return to work or find other funding sources to pay for necessary medical procedures and transportation to the hospital.
- There is a concern that elderly people are taken to emergency in an ambulance and scheduled for a diagnostic test but are then sent home to wait for the test.
- The dentists' drafted bylaws made reference to the practice of certified Dental Assistants within Government public health programs. The draft dentists' bylaws reference certified dental assisting practice within government public health programs. These bylaws do not address the needs of specific target groups such as the homeless, working poor, the disadvantaged, new immigrants, and First Nations. These are marginalized populations who have little or no access to oral health promotion and preventive services. Additionally, the draft omits protocols and delivery of service in long-term care, seniors' residential care institutions, and home care despite a growing need for professional assistance in all of these chronic care situations.

Ideas and Suggestions

Leadership and Structure of the Health Care System
Wait-lists and Access to Health Care
Wait-lists for Specific Groups and Marginalized Populations

- Ideas about leadership and structure of the health care system:
  - Ensure there is a fair system for wait-times that are similar province wide.
  - Ask the public how long they think they should wait for a particular service as a starting point.
  - Initiate a public awareness campaign that helps people understand that some waiting for certain procedures is not unreasonable.
  - Set up an accountability system set up to ensure that people receive quality care in a timely manner.
  - Solutions for long wait-lists exist in our public system and include applying new technology and techniques, using public clinics, and improving work conditions and decreasing overtime to retain staff.
  - Have a wait-time advocate to engage politicians and inspire care providers to address wait-times.
  - To reduce wait-lists focus on improving efficiency and ensuring appropriateness and equity of care need. Knee-jerk reactions which throw more money at the system in the hope of increasing patient flow will not remove the problem.
  - Better management of wait-lists requires physicians to make the shift from working individually to working in teams with their specialty group, with primary care physicians, and other members of the health care team. These changes would require leadership from the Provincial Government which to date has not been forthcoming. Instead of promoting private solutions, the Government should build on the success of these projects by making them the rule rather than the exception province-wide.
  - Give the public the opportunity to share their thoughts, comments, concerns, ideas and solutions on wait-lists.

- Ideas about waitlists and access to health care:
  - Identify areas around British Columbia that are most in need and hire staff from other provinces on a limited basis to clear the backlog.
  - To reduce wait-lists we need the equivalent of 24 hours seven days a week walk-in clinics associated with emergency departments because many people do not know whether their problem is urgent or not, do not have access to a family doctor or cannot schedule their illnesses for convenience.
  - Extend the hours of medical clinics and triage centers to provide medical attention to people after hours and reduce wait-lists and visits to emergency wards.
  - Apply early intervention and address health concerns in a timely, holistic and coordinated manner to reduce wait- lists, better manage illness, and achieve wellness faster.
  - Reduce wait-times by defining medically necessary procedures.
- Ideas about specific groups and marginalized populations:
  - Provide resources and create more awareness for sufferers of chronic health diseases. This includes increasing affordability of medications and vaccinations for chronic health disease clients and hiring a chronic health disease advocate to put these things in place.
  - Ensure youth have access to medicine, a decent health care system, and information.
  - Share knowledge and best practices to improve wait-list management, particularly those wait-lists that affect children and families.
  - Change legislation that says that low income families who do not qualify for any provincial subsidized programs but may be able to afford one visit per year per family member with a dental hygienist, must be examined by a dentist before they can have preventative health services by a dental hygienist. This is an additional expense which makes access to preventative dental care prohibitive.

Management and Administration of Wait-lists

Comments and Concerns

Quality and Efficiency of Wait-list Management
Wait-list Management for Specific Illnesses and Procedures
Wait-list Management in Other Jurisdictions
Bed Management
Surgical Wait-list Databases and Registries
Wait-list Measurement, Benchmarks and Guarantees
Wait-lists and Wait-times and Health Care Professionals

- Comments on quality and efficiency of wait-list management:
  - Wait-lists do not appear to be well managed or organised.
  - Wait-lists are unmanageable and overwhelm doctors and nurses.
  - Wait-lists are determined by categorising the procedure into elective or life-threatening, but the elective category includes such a broad scope of care that it plugs up the system.
  - There is little debate that long waits are unacceptable for certain surgical procedures. There is less agreement regarding what to do about it. Some researchers describe waiting lists as a function of a funnel and spout. Wait-times depend both on how many people are told that they need a service (the funnel) and how many people are regularly receiving it (the spout). Increasing capacity for one service can increase the size of the spout, but without other changes, may make the spout for another service smaller. At the same time, increasing capacity can cause physicians to refer more patients for that service, thereby increasing the size of the funnel. If both of these occur, more people may well be receiving the service, but wait-times may not be affected at all, or may even increase.
  - Wait-times and delays for care are not usually due to a lack of resources, but to poorly organized services. Shoddy or non-existent coordination, lack of flow and lack of consistency are some of the organizational problems contributing to health care bottlenecks. Inconsistencies or variations slow the flow and delay needed interventions. For example, every day valuable operating room time is taken up by the re-making and re-supplying of operating rooms according to the individual preferences of surgeons, even those doing identical procedures. Variation on any point along the continuum of care slows the system down. Most

variation, however, arises from inefficiencies in the system and not from unpredictable elements such as changes in a patient's condition.

- The recent agreement between the British Columbia Ministry of Health and Health Authorities may significantly limit the Province's ability to rectify the wait-list problem. This agreement appears to leave much of the wait-list management and coordination to individual physicians. It also appears to restrict the ability of Health Authorities to re-direct patients.
- Wait-times cannot be effectively reduced without substantive improvements to the province's operating room strategy.
- The issue is getting the best service when needed without having to pay for that service out of your own pocket. If the health services were managed correctly there would not be an issue of wait-lists and extra costs.
- Wait-lists are lengthening due to a lack of preventative measures.
- Wait-times are due to a lack of solid, hard-nosed management of hospitals.
- Regionalisation has improved wait-list times.
- People with priorities get quick treatment.
- Length of stay data has shown huge decreases due to improved technology and moving people quicker.
- The focus on wait-time priority areas has not crowded out other types of surgery, although trends do vary across the country for specific types of surgery.
- There is a concern that the public's information indicates British Columbia has doctors available, available operating rooms, and diagnostic equipment but we do not have an operational management system in place to co-ordinate it all.
- There is a lot of skepticism concerning the information provided about wait-lists.
- Wait-times for some services such as laboratory tests and radiology are done quickly and locally, but there are long waits for diagnosis and treatment.
- If wait-lists are getting longer we need to be able to do a blitz to reduce them and then go back to normal procedures.
- There is no average patient and no average wait-time, as we are dealing with situations that vary by the type of care needed, the sense of urgency, which wait-list the patient is on and what organization manages that wait-list, as well as other factors related to an individual patient's conditions.

- Comments on wait-list management for specific illnesses and procedures:
  - Wait-lists for hips and knees are down from two years to about 12 to14 months. This is still not good, but it is better.
  - The protocol and wait-lists for diabetics to receive pancreatic surgery is too restrictive in British Columbia.
  - Lower-joint care is currently delivered on a position-in-cue not need basis. The system must provide people the care that they need when they need it, not in relation to their position in the cue.
  - There are short wait-times to treat breast cancer.
- Comments on wait-list management in other jurisdictions:
  - An Irish study converted a time-based waiting list to one based on clinical need resulting in a substantial decrease in the waiting list.
  - One Toronto hospital reduced wait-times for lung cancer by making changes to scheduling and referral practices, adopting performance standards and improving multi-disciplinary communication. As a result, wait-times were reduced by 71 per cent.
  - In 2004, Ontario launched its Wait-Time Strategy, a multi-pronged effort to reduce wait-times that cost almost a billion dollars. Ontario targeted five high demand areas: cardiac revascularization procedures, cancer surgery, cataract surgery, hip and knee joint replacements, Magnetic Resonance Imaging and Cat Sans. The strategy's first goal was to reduce times for 90 per cent of patients waiting for treatment in those areas by December 2006. That goal has been achieved, albeit more successfully in some areas than others. According to the government's latest update (September 2006), it met all targets for cancer and cardiac bypass surgery, but has not yet for other areas
  - Alberta reduced wait-times for hip and knee replacements by implementing a standardized referral tool, a single point of entry as well as other organizational changes. As a result, wait-time to see a specialist has fallen from eight months to six weeks. Alberta has also decreased the time required to go from decision to operate to actual surgery by optimizing patients' conditions and implementing alternative plans for care.

- Comments on bed management:
  - Poor bed management leads to longer wait-times. A sampling of British Columbians concerns on this include:
    a. poor exit planning so patients occupy beds longer than necessary;
    b. blocking beds to indicate that they are full when they are not;
    c. patients using beds while waiting for beds in other areas;
    d. lack of recovery beds; and
    e. patients occupy beds who would be better off in a long-term care facility or at home with quality home care.
- Comments on surgical wait-list databases and registries:
  - British Columbia's current internet wait-list registry is inaccurate, inconsistent and difficult to use as a management tool. On the whole, information on surgical services in British Columbia is out-dated, as it is elsewhere.
  - At the base of the wait list discussion and the proposed provincial surgical registry is the unwritten concern that some may view specialist services as interchangeable; that both quality and outcomes are similar for patients and their agent, their family physician. The traditional model has reinforced a different relationship; the system regulator prefers to have the quality of this specialist services observed by another physician through referral by a primary care physician. At the centre of the wait list discussion we therefore find an attempt to change the pattern of referrals raising questions for change managers and policy makers in a number of areas: costs of developing referrals, issues of ownership of waiting lists, list sharing, valuation (goodwill), cost recovery for maintaining lists, and access to surgery to the extent that the length of wait lists are factors in determining surgical block allocations. All of these open issues are change related and until resolved create system-culture tension.
  - The new Surgical Patient Registry is way too comprehensive and not accepted by all physicians.
  - There is not one source for the general public to find wait-list information for both private and public facilities for certain services in British Columbia. This information seems to be scattered on the internet amongst various web sites.

- There is concern about the accuracy of the provincial wait-list website. According to this website, the median wait for the surgeon that I have is 11 weeks. However, I have already been waiting nine weeks and was informed that it will take up to at least 12 more weeks.
- The Saskatchewan Surgical Care Network (SSCN) is the most comprehensive surgical database in Canada and the foundation for several other provinces currently implementing their registries, as it is a pro-active rather than passive system. Pro-active registries start with firm and daily updated data gathered in a consistent and standardized way. This information can then be used by patients, physicians and more importantly health authorities to shorten wait-times for care. Active registries are more about managing wait-times than they are about reporting wait-times. It must be emphasized, however, that no registry and no wait-list whether it is active or passive prevents patients from choosing a specific surgeon. Patients always have the right to choose who will perform their particular procedure; however, depending on their choice they may have to wait longer.
- Two years ago, the Province launched the Provincial Surgical Services Project, an ambitious collaborative effort between the Ministry of Health, the Province's six health authorities, practicing surgeons, the British Columbia Medical Association, the University of British Columbia's Faculty of Medicine and the British Columbia Medical Services Commission. The goal of the Provincial Surgical Services Project is to reorganize surgical care to make it fairer, timelier and more appropriate for patients. After more than two years and five million dollars in capital funding, its new British Columbia Surgical Patient Registry is approaching completion. This real-time, web-based registry is capable of reliably tracking all patients waiting for all elective surgeries in British Columbia.
- The provincial surgical wait-list is difficult to understand, as it has no common definition, criteria or rules.

- Comments on wait-list measurement, benchmarks and guarantees:
  - There is no comprehensive and consistent measurement for wait-lists.
  - People want a hard number to inspire confidence. It is the uncertainty that puts people off, not the length of time. We know that the overall number of surgeries is up in priority areas, but we do not actually know what effect this is having on wait-times because we do not have comparable data to track wait-times and trends across the country.

- Provincial governments appear nervous about the introduction of guarantees due to the potential financial obligation they represent, as well as public reaction in the event they are not met. One small step in this direction was made when the Federal Government announced on April 4, 2007 that all provinces would commit to at least one wait-time guarantee. British Columbia is to implement an eight week guarantee for radiation therapy for cancer by 2010. However, the average wait-time for radiation therapy in British Columbia is typically less than three weeks so a wait-time guarantee of eight weeks is not onerous. Furthermore, no recourse has been explicitly outlined if the British Columbia Government does not meet this mark.
- Government imposed wait-list guarantees for a few procedures simply do not measure up. With inflexible funds and health care human resources, wait-list guarantees simply serve to reallocate precious health care resources to issues at the top of the political agenda.
- The doctor or health care provider is the first person to visit so represents the first wait-list. The referral to the specialist is the second wait-list. We need to agree on a true standard wait-list.

- Comments on wait-lists and wait-times and health care professionals:
  - Long wait-lists cause inefficiencies in the system such as nurses performing administrative tasks.
  - The surgical process before, during and after an operation is technically complex and multi-faceted. It includes preparation for surgery, hospital admission, anaesthesia, surgical procedure, recovery and involves a wide range of health professionals working in different areas in a hospital and community. Traditionally, the system has relied on individual physicians and their office staff to manage and direct the many steps in this process. For example, it is up to surgeons and their office staff to make multiple appointments for patients with specialists, laboratories, radiology facilities and operating rooms. Because one appointment is often dependent on the outcome of another and because no one is organizing patient traffic as a whole, congestion can occur at every stage.
  - Currently within health care delivery systems, it is not in the interest of patients or medical practitioners to spend time screening for and treating those issues which can be addressed expeditiously and effectively with routine, non-invasive, cost effective chiropractic treatment.

- Doctors that retire leave orphaned patients who have to wait a long time to find another doctor and receive medical attention.
- Wait-lists are long because there are not enough health care professionals, especially specialists and anaesthesiologists.
- Government could open operating rooms, but surgeons only have so much time to spare to do the procedure. This is because they are just as concerned about operating an office to generate the wait-list.
- People want to visit their family doctor instead of a walk-in clinic so they do not have to wait. However, people have to wait one week or more to see their doctor and then wait again in the doctor's office because the doctor is so backlogged.
- To make wait-lists shorter doctors need to ensure that the right patient has the right procedure. This may mean not having the procedure at all. Although seldom discussed in the media some medical interventions are inappropriate because they are needless or may actually do harm. If those patients who would not benefit from a surgery were screened out, then wait-lists would be shorter.
- There is a concern that people have to wait for many months to see a surgeon and then they still have to wait for the necessary procedure.
- I work for a rheumatologist. Our referrals to orthopaedic surgeons, Magnetic Resonance Imaging (MRI), cat scans and bone scans are unacceptable. A one year wait for Magnetic Resonance Imaging (MRI) and a two-year wait to see an Orthopaedic Surgeon are unreasonable.
- The present system used for surgery wait-lists has a patient assigned to a specific surgeon's wait-list. If this surgeon stops practicing then the wait-listed patient is moved to the bottom of a new surgeons list. This is an unfair and potentially dangerous situation since a person can be lost in the system and have their wait-time extended because of circumstances beyond their control.
- There is a concern that doctors double book patients (two patients per five minute time slots) so doctors can maximize their income and force patients to wait over an hour to see them for less than two minutes.
- Wait-times must take into account the time that one has to wait to obtain a doctor's services, get the necessary investigations and then wait to see a specialist.
- Wait-lists to see specialists will increase by additional referrals from Nurse Practitioners.

Ideas and Suggestions

Quality and Efficiency of Wait-list Management
Priority Wait-lists and Patient Flow
Wait-list Management for Specific Illnesses and Procedures
Bed Management
Surgical Wait-list Databases and Registries
Information Systems
Wait-list Measurement, Benchmarks and Guarantees
Wait-lists and Wait-times and Health Care Professionals

- Ideas about quality and efficiency of wait-list management:
  - Make all wait-lists public.
  - Ensure patients receive their test results in a more timely fashion.
  - Review referral processes, manage schedules more effectively and utilize community for more traditional tertiary services to shorten wait-lists.
  - Create two wait-lists, one that elective and one for non-elective surgery.
  - There needs to be strategic and objective planning to reduce wait-lists.
  - Wait-list management should start with diagnosis.
  - A third party such as the Health Authority or a committee should take over wait-list management.
  - Go back to three care diagnosis: life-threatening; necessary care (not immediate but required to assist in quality of life); and elective but not medically necessary.
  - Understand the clues contributing to long wait-lists to enable them to be reduced. For instance, patients transferred between hospitals and those who arrive at hospital on a week day rather than a weekend will likely have a longer wait-time, while those admitted to large community or teaching hospitals may have less of a wait-time.
  - Reduce wait-lists by ensuring that tests and procedures are done in one visit.
  - Ensure comprehensive utilization of resources from home to facility and back to home including human resources, equipment, beds, home care and support without spending more.
  - The Health Authorities should maintain wait-lists on a single, coordinated list.

- Adopt a single common waiting list rather than a multitude of lists managed by individual doctors or facilities.
- Adopt queuing strategies to improve current organizational processes.
- Eliminate wait-times for Medical Resonance Imaging (MRI) by offering this service in the communities, like x-rays and ultrasounds are.
- Reduce wait-lists by identifying certain hospitals as having operating or diagnostic testing services that cannot be bumped by emergencies.
- Jumping a surgery wait-list for medically covered services should not be allowed unless the service is provided by a physician that is not enrolled or has de-enrolled from the British Columbia Medical Services Plan.
- Before services are provided to those on wait-lists there should be a medical evaluations and advice o determine a patient's degree of pain, discomfort, and inability to lead a normal life.
- Find out how much time doctors can safely spend in surgery each week and then provide them the operating room time to be able to do it.
- Have an impartial board of health care professionals determine wait-time guarantees then find the resources for a publicly funded health care system to meet those guarantees.
- Reduce wait-lists by focusing on health promotion like subsidising gym memberships, providing support to help people quit smoking, and providing information and cooking lessons in schools to promote healthy lifestyles.
- Patients who are bumped from scheduled surgery for emergencies should not go to the bottom of the list, but should be rescheduled as a priority.
- Remove the waiting room in emergency departments. If there is no waiting room, then perhaps people may shift toward information centers where people could be educated while they wait.
- Analyse what the statistics on wait-times are really saying. One person wrote that they waited for one year for eye cataract surgery because he wanted a specific surgeon. He said that he could have had the surgery sooner by going to a different doctor.
- Focus on how many surgeries should be done in this population, rather than how many surgeries have been done.

- Redefine what an elective surgery is. When a patient is in pain 24 hours and seven days a week, it is not elective.
- Make hospitals that are in close proximity to each other specialize in certain areas.
- It has been mandated that urgent cataract surgery should be done within four months. One specialist writes that he is unable to come close to maintaining this standard due to the chronic lack of operating room time available.
- The question of what are safe wait-times can only be answered by doctors and they are currently working to establish those times.

- Ideas about priority wait-lists and patient flow:
  - We need variation in processes and patient flow to reduce wait-lists not just to provide more access.
  - Eliminate priorities for special groups such as Worker's Compensation Board, Department of National Defence, the RCMP and prisoners.
  - Adopt pre-surgical programs that prepare patients physically and mentally for surgery.
  - Create a priority wait-list for patients who have had previous diagnosis and surgery because doctors have access to their previous medical history.
  - Prioritize wait-lists based on need and personal actions. This would include a point system where smokers and obese people get fewer points for their lifestyle choices and therefore would have to wait longer for services.
  - Prioritize patients on wait-lists according to the level of care that they require.
  - Implement and support the effective solutions that can reduce bottlenecks and improve patient flow for elective surgeries, these include:
    a. pooling patients onto a common wait-list;
    b. pre-screening and educating all patients facing surgery;
    c. discharge planning before surgery;
    d. ensuring that home care arrangements are in place to decrease the chance patients will need re-admission;
    e. begin all surgeries on time to lessen the chance of backup;
    f. standardize surgical equipment by procedure rather than by surgeon preference to assist operations to be done more efficiently and to enable bulk buying of equipment;

g. when appropriate, physician preference information needs to be current and easily accessible;
h. booking groups of similar procedures together;
i. modernizing electronic information systems;
j. standardize patient care protocols to ensure all patients receive the best post-operative care; and
k. support advanced practice Registered Nurses and Nurse Practitioners who can be trained for such roles as anaesthetist or surgical assistants.

- Ideas about wait-list management for specific illnesses and procedures:
  - Reduce wait-lists for drug addiction treatment centers.
  - Patients who are waiting for cancer treatment should be prioritized to a maximum wait-time thought to be reasonable for that disease.
- Ideas about bed management:
  - Patients who are discharged early for bed utilization do not lose procedural priority.
  - A British report noted that the single most important way to improve wait-times in emergency and to reduce the number of cancelled surgeries is to ensure more beds are available. One of the main ways to guarantee more beds is to improve community care, yet British Columbia has moved in the opposite direction. According to a 2005 report by the Canadian Centre for Policy Alternatives, access to long-term care and home health services decreased significantly between 2001 and 2004, in spite of an aging population and cuts to the acute care system. Thus, expanding community health care represents another vital means of taking pressure off the more expensive acute care system and enhancing the flow of elective surgeries.
  - Improve bed management to reduce wait-lists.
  - Provide more long term-beds outside of hospitals.
- Ideas about information systems:
  - Create a Province-wide referral system for surgery and diagnostic testing to reduce wait-times.
  - Implement a common system for reporting with common definitions such as the Calgary data system.

- Implement a system to evaluate wait-list status.
- Hospitals need to create a booking system to manage wait-lists collectively and use electronic health records.
- Faster reporting of test results such as by electronic reporting would reduce waiting time.
- Allow patients transparent access to existing assessment diagnostic and treatment options.
- Educate people on the facts of wait-lists, so they have more than the emotional media hype on the fear and/or loss of services.
- Wait-list management is about developing a global approach driven by fair, transparent and commonly defined data that meets the local patient population needs, not provincial targets, and focuses on improved triage systems.
- Give patients waiting in emergency rooms an idea of where they were on the list by using a numbering system or something similar.
- Institute a wait-time information system, similar to the system in Ontario, that hospitals have the option of joining.

- Ideas about surgical wait-list databases and registries:
  - Provide patients the ability to see what the wait-list times are for individual surgeons.
  - Coordinate universal and standardized assessment for surgery wait-lists.
  - Establish an on-line system to allow patients to compare time for elective surgery at various hospitals. This would allow those patients who are healthy enough and have adequate financial resources to travel to other facilities thereby helping to balance out the workload of institutions.
  - Reducing wait-times requires a set of enhanced management tools such as central registries like the Surgical Waitlist Registry, clinical guidelines, best practices, information technology, financial incentives, overcapacity protocols and clinical prioritization tools. For instance, the Surgical Waitlist Registry provides a standardized tool for surgeons to prioritize patients on wait-lists, so British Columbia has a more consistent and accurate approach to managing wait-lists for all surgeries. This registry improves the accuracy and reporting of wait-list data to ensure that patients with the highest urgency are served first.

- Reduce surgery wait-lists and wait-times in emergency departments by introducing heavy performance-based financial penalties and bonuses for medical administrators.
- Identify maximum timeframes for meeting the medical needs of our population. For instance, if it is critical, it should be dealt with in a specific amount of time, if it is surgery, such as a hip replacement, it should be dealt in a specific amount of time and so on. Without a base line, people are waiting years for surgeries that would improve their quality of life.
- Review the new Surgical Patient Registry and scale it back to a manageable product.

- Ideas about wait-list measurement, benchmarks and guarantees:
  - British Columbia should establish maximum wait-times and then abide by them.
  - If British Columbia truly wants to better define accessibility in law, then it must have the courage to implement meaningful guarantees.
  - Set performance measures and benchmarks in the system to promote accountability.
  - Implement overall monitoring and benchmarking based on best practices to get wait-list management data that government can trust.
  - Follow the British model to set hard targets for maximum wait- times.
  - Set realistic targets for elective and urgent procedures.
  - Define and communicate targets for wait-lists and track performance in meeting targets.
  - Set specific timeframes for particular processes such as blood tests and injections.
  - The British Columbia Government should establish evidence based wait-time benchmarks that set up a safety valve to address situations where the established time guarantees are not met. This safety valve provision would allow patients and their physicians to seek required care wherever it is available, if the designated service is not provided to patients in the originally referred location and within the guaranteed time period. Treatment could be obtained at another public facility in or out of province, or in a private facility, in or out of country.
  - Continue and expand the work of the Canadian Wait-Time Alliance, which is preparing clinically driven benchmarks in the areas of emergency, psychiatric care and reconstructive surgery. These benchmarks will extend the focus beyond the

five priority clinical areas and begin to provide benchmarks across the continuum of health care services.

- Educate and support patient knowledge about wait-lists so the patient is part of the team.
- Implement evidence-based maximum wait-time benchmarks. To do so, consider the work that has already been done on the issue of wait-lists, including: *Western Canada Wait-list Project* (2000-2005), Federal Wait-time Benchmarks, Canadian Wait-time Alliance, British Columbia Surgical Patient Registry, and the British Columbia Medical Association Position on *Emergency Room Overcrowding* (2006).
- Meaningful wait-time benchmarks must be based on medical outcome evidence and professional opinion. Such work has already been done by the Wait-Time Alliance, whose members include eleven medical specialty societies and the Canadian Medical Association. In 2005, the Wait-Time Alliance established evidence-based benchmarks in the following five priority areas: radiology, nuclear medicine such as diagnostic imaging, joint replacement, cancer care, sight restoration and cardiac care. These areas were outlined in the 2004 First Ministers 10-Year Plan to Strengthen Health Care. The Wait-Time Alliance emphasized that the intent of these wait-time benchmarks was to be considered health system performance goals that reflect a broad consensus on medically reasonable wait-times for health services delivered to patients.
- Make the ten key benchmarks that the health ministers across Canada unveiled in December 2005 legally binding. These benchmarks reflect the time that clinical evidence shows is appropriate to wait for a particular procedure; however, they are not binding on any provincial or territorial government.
- The British Columbia Government should commit to implementing wait-time guarantees. Over the past several years the federal government, in cooperation with the provinces, has made a commitment towards implementing wait-time guarantees. The March 2007 Federal budget announced up to $612 million to support jurisdictions that have made commitments to implement patient wait-time guarantees. British Columbia's share of this funding, if allocated on a per capita basis, would be approximately $60 million; this is in addition to the estimated $715 million British Columbia is scheduled to receive as part of the ten year Wait-Time Reduction Fund announced in 2004.
- If any Province cannot meet the wait-time target, then it must offer the option of having the procedure done elsewhere in Canada or the United States, at no cost to the patient.

- Establish maximum wait-time guarantees for the more common surgical and diagnostic procedures and be prepared to have these procedures delivered in private facilities and funded by the Government in order to stay within these guarantees.
- Define reasonable access that includes wait-list guarantees so that there are set and firm time limits as to how long a patient needs to wait and/or travel in order to get access to health care.
- The National Health System web site in the United Kingdom provides weekly, monthly and annual wait-times and identifies wait-time targets, which ensures accountability.

- Ideas about wait-lists and wait-times and health professionals:
  - Keep doctors up-to-date as to the status of wait-lists and current literature on criteria for ordering tests.
  - Adopt team based care that enables providers such as nurses to assume broader clinical tasks while working within their scope of practice.
  - Pass legislation that doctor appointments are at least 10 minutes.
  - Find a way to enable all practitioners to know a patient's history.
  - To decrease wait-lists for specialists give doctors more time to think, investigate and talk to patients so referrals may not be necessary.
  - There needs to be a system in place for doctors and specialists to be accountable for excessive long wait-times for appointments.
  - Model an Albertan pilot project where a nurse and physiotherapist triage joint replacement candidates and refer them to orthopaedic surgeons. The Alberta pilot project successfully decreased wait-times to see orthopaedic surgeons from eight or more months to weeks.
  - Provide temporary assistance to family doctors to clear their backlog of appointments.
  - Make greater use of nurses and nurse practitioners.
  - Facilitate cooperation between specialists and find ways for them to combine wait-lists.
  - Require follow-up on patients that are on wait-lists and involve local physicians in patient care.

- Effective triage can reduce treatment and wait-times and improve utilization of resources.
- Reduce wait-lists by looking at scope of practice such as using operating technicians instead of doctors.
- Patients should be put on wait-lists for the hospital that is close to where they reside. The patient would then be assigned to the next available surgeon on the list for treatment. If the patient is bumped then they should be scheduled into the surgeons next surgical slot and the other patients surgical times moved back one surgical slot.
- Ensure health professionals have the proper diagnostic tools to be able to expedite diagnosis to alleviate bottlenecks in various health areas.
- Wait-times which are dependant on a physician's availability to see patients could be lessened with the involvement of Nurse Practitioners in our health care system.
- Provide an incentive to surgeons to do more operations. In Ontario, the more procedures surgeons do the more money they make and as a result wait-times are slashed.
- Limit wait-lists for all surgeons to three months, as there are other surgeons with low volumes who could do more work.
- Reduce wait-times by covering chiropractic care and help to avoid more serious, unnecessary surgeries and other related costly interventions.
- Having more health care professionals, such as nurses, nurse practitioners, doctors, physiotherapists, dieticians, etcetera, available in a community in an easily-accessible setting would decrease wait-times for appropriate services.
- Ensure more efficient utilization of health human resources so it is more cost effective for the public.

Health Impacts of Wait-lists

Comments and Concerns

Negative Impacts of Wait-Lists

- Comments on the negative health impacts of wait-lists:
  - Long wait-times in waiting rooms can end up giving you more problems than you went in with, as well as exposing others to your illness or disease.
  - Waiting too long to get test results from your doctor can delay getting definitive treatment.
  - Governments still fail to recognize the June 9, 2005 Supreme Court of Canada ruling that stated that delays in the public health care system are widespread and patients die as a result of waiting for public health care.
  - The Canadian Institute for Health Information (2003) data tells us that we know very little about wait times: how they compare across the country, what percentages fall within the recommended guidelines, and in particular what is the emotional and physical impact of waiting for care.
  - Too many people are off work due to some ailment or illness while waiting for months or years for diagnosis and treatment. This is a huge problem and causes sick people to become worse. People off work costs us more money in employment insurance, insurance claims, lost business and training temporary help.
  - Long wait-lists lead to further health issues, chronic problems and result in a poorer quality of life. Here are some concerns from British Columbians on this issue:
    a. I had to wait on a four month wait-list for my eye surgery which would have helped or slowed down early onset macular degeneration.
    b. I was on a three year wait-list for a 20 minute operation. This led to losing my job, a lack of mobility and extra costs to the system.
    c. A long wait-list to see a psychiatrist was very stressful for the entire family.
    d. By the time people find out what really is wrong, they have had cancer for five to six years without knowing it;
    e. Patients who are waiting for care become progressively sicker and care becomes more difficult, longer and more expensive.

f. Extended wait-times (over six months) for diagnosis and treatment increases the complexity of the health problem and reduces the possibility for resolution.
g. There is a lack of organs available, which causes very long wait-times and high medical costs as a patient's acuity escalates, some even dying.
h. Peripheral costs to being on a wait-list include waiting in pain, poor mental health, stress on work and family life, and damage to other body parts.
i. Delays to surgery cause patients to make more visits to their doctor to ask for more prescriptions. Wait-lists encourage doctors to prescribe more.
j. Waiting in the emergency department for long periods of time for simple procedures takes a toll on patients and can sometimes cause shortened life spans.
k. I had to pay privately for Magnetic Resonance Imaging (MRI) because I was not willing to wait another four months for one to determine whether or not I had a brain tumour. I found out that I have Multiple Sclerosis and now I face long wait-lists for continuing care by my neurologist.
l. It is cruel to make people wait many months and in many cases years, when they are in pain. Whatever the person is suffering from may well be incurable or inoperable by the time they are seen by a specialist and/or operated on.
m. One should not have to wait three months for day surgery. The long wait is causing deterioration in my husband's health.
n. My 58 year old sister's knee replacement is nowhere in sight, neither is her knee cap, as it is somewhere on the side of her leg. Waiting for her knee replacement is becoming extremely difficult as she sometimes falls due to her swollen damaged knee. Do you recommend welfare and pain killers when she can no longer work.
o. Long waiting lists for high profile procedures such as cataract surgery and hip and knee replacements have caught the attention of the media, public and governments. People can wait many months, in some cases more than a year, for surgery that could have an enormous affect on their quality of life. Replacement of a painful knee can improve or reinstate basic mobility, reduce or even eliminate constant pain, and can allow patients to return to long abandoned activities. Removal of a cataract can have similarly dramatic effects, allowing people to retain (or regain) their independence.

p. It will take me four months to see a gynecologist. Although my condition is not life threatening I am suffering from symptoms and cannot understand why there would be a four month waiting list.

q. I have recently been diagnosed with Arterial Fibrillation and my cardiologist suggested a procedure called Pulmonary Vein Ablation. The cardiologist placed my name on the list in August 2006 and I may get a consultation with him in the fall 2007. The procedure itself will be approximately one year after that. By that time I will be 67 years old. The bonus is that the longer I wait, the less likely the procedure will be successful and so I may be disqualified as a candidate for this procedure.

r. My father has been waiting for a heart operation since the fall 2006. Although the surgeon is ready to operate he cannot due to hospital cutbacks.

s. It took me from February to October to finally be scheduled for a much needed surgery to drain a cyst that was attached to my pancreas from another ailment. This operation should have been done in three or four months, but I waited nine months.

t. I had the unfortunate experience of witnessing my 94-year old patient's frustration of having to wait for hip surgery. The patient could not eat for two days (protocol for undergoing surgery) and was transferred to and from his bed to a stretcher for endless hip x-rays, making him scream in pain. It is simply ridiculous.

u. I am currently waiting for total knee replacements and have been waiting for over two years.

v. After waiting four years for an orthopaedic surgery, I am going to Ottawa to have it done.

w. I know an active healthy senior who requires knee surgery. He has been waiting for two years and his surgeon said he should not expect the surgery anytime soon because there is such limited operating time available and he has to prioritise patients.

x. It took almost two years for me to see a surgeon. The two year waiting list that the British Columbia Government thinks is okay has destroyed my life.

y. I have just waited five months for a mammogram appointment even though I have in fact had breast cancer and have been advised to have a mammogram every year.

z. I must wait one year before I can see an ear, nose and throat specialist. This delay may result in the loss of my other ear drum and I will become deaf.

aa. It took 18 months to get to an appointment in a chronic pain management centre in Kelowna. It also took 12 months to get an appointment with a sleep disorder specialist where sleep apnea was suspected, which is life threatening.

bb. I was in excellent physical health but had an injury. I was disabled for nine months due to long wait-lists in the medical treatment system. Thank goodness I had the option to pay for the procedure privately even though I had to pay for it on my credit card.

cc. My mother was diagnosed with cancer, but by the time she sees an oncologist it will have been six weeks since diagnosis without any action taken to arrest or treat her condition.

dd. Our son had a bad shoulder injury, but because we did not have knowledge and the doctor did not give it due attention and he is now disabled (after three operations). The fact that he had to wait nine months for surgery was wrong.

ee. My husband had an electrocardiogram, blood test and stress test this summer, all of which indicated an urgent cardiac disease. He was then put on a five and one half month wait-list for a diagnostic angiogram in Kelowna. We ended up going to Seattle for the angiogram, which only had a one week wait. Good thing we did as he had to undergo emergency life saving open heart surgery the next day. Now our wonderful British Columbia medical system will not pay any part of it, as they say that acceptable and appropriate care was available in British Columbia. He would have died if we had not gone outside the Province.

ff. My wife and I just paid over $2,000 for her to have her knee operated on because she could not wait another year for the medical system to get around to her; and

gg. My surgeon has an elective waiting time of over five years. Patients with tumours and so on are fast-tracked for surgery, but patients with benign diseases have long waits to access the public system, even though these diseases greatly affect their quality of life.

hh. I suffered much stress waiting for tests, treatment and cancer surgery for most of 2005.

Ideas and Suggestions

- Provide care to patients before their health affliction or concern becomes disabling or causes other damage.
- Pay for in-home care for patients on wait-lists for surgery.
- Reinstate family and support services for patients on wait-lists.

Funding and Health Care Models

Comments and Concerns

Capacity
Costs and Funding
Health Care Models

- Comments on capacity:
  - Expanding capacity has been a focus for governments across Canada in recent years, with particular attention paid to priority areas such as hip and knee replacements, cardiac, cataract and cancer surgery. The result has been significant increases in volumes of surgery in each of these areas across the board. The number of cases was up 12 per cent over five years, even after adjusting for population growth and aging.
  - Long wait-lists are due to a lack of testing facilities.
  - Operating room availability (7:00 am to 3:00 pm) means that equipment is only used part-time.
  - Three years ago, the Interior Health Authority region had six operating room booking systems at nine sites. Now one system serves 11 sites.
  - The private use of Vancouver Hospital scanning systems is in violation of the *Canada Health Act*. We are now faced with the reality that these hugely expensive resources will sit idle for a good percentage of their lives. This means that at least 1,100 patients over three years will have to be slotted into the already lengthy wait-lists for scans, and our economy has been robbed of 1,100 patients times $1,400 or $1.54 million.

- Comments on costs and funding:
  - Wait-lists and wait-times for sonograms, procedures, tests, scans, and so on, are under-funded to promote private treatment and care.
  - Treating someone quickly saves money. This is evidenced by the Worker's Compensation Board, which is the only organization in Canada with flat health care costs.
  - Wait-lists cost more money because of the huge overtime wages paid out to keep shifts covered.
  - The longer the wait-list the more it costs the system. These costs include more prescription medications while patients wait for surgeries, more invasive surgeries and more intensive treatments as a result of the delay. Closing hospitals and surgery rooms actually end up costing more through complications in the long run.
  - It is much cheaper for the Government to pay for the needed surgery quickly in order to save money. Although the same argument cannot be made for a senior citizen who suffers from an affliction, as they are unlikely to qualify for employment insurance or welfare and their tax base is unlikely to go up or down whether they have the surgery or not. However, the costs for medication and possible costs associated with needing to provide a higher level of care for those seniors may show a similar result (shorter wait-times = less costs).
  - Technology testing equipment made available by Hospital Foundation funding has improved wait-list times.
  - A major reason for wait-lists is that the public hospitals have to accurately budget each year. They are penalised if they go over budget and also if they are under budget because the extra money is recaptured and a smaller allowance is allocated for the next year. The demand for health care especially surgeries is hard to predict so the hospital manages by controlling the access to operating theatres.
  - Government withholds funding that is required and then it appropriates $20 million to pay towards private clinics for providing services and reducing waiting lists. Government ideology is creating wait-lists.
  - Mental health wait-lists and counselling are tragically under-funded, especially in rural and small areas.

- Ministry funding may not meet local priorities.
- My cardiologist advises me to have an ablation operation, but I have to wait months for the procedure because he is only able to operate one week per month even though a second operating theatre at his hospital sits vacant due to under-funding.
- Waiting time for elective surgeries, such as knee and hip surgery, has been increasing because there is not enough funding given to the Interior Health Authority to reduce waiting times.
- The present health care delivery model is ignored and under-funded leaving people to suffer needlessly and sometimes even die while on wait-lists.
- There is a problem that physicians are available to do surgeries and the space to do them is available, but Government imposes limitations on the number of surgeries that they pay for. This limits the options of patients to either go on a wait-list or to a private clinic.

- Comments on health care models:
  - Health Care Commissioner, Roy Romanow reported to the federal government in 2002 that long waiting times are the main reason why some Canadians say they would be willing to pay for treatments outside of the public health care system.
  - I personally would be willing to pay a reasonable amount (based on income) towards timely care in another location rather than suffer on a wait list again.
  - Wait-lists are far too long and force the average person to have no choice but to take part in the extremely lucrative private sector options.
  - I accept wait-lists for certain procedures if it means staying true to the principles of universal access and public health care.
  - Do not discriminate on the ability to pay in relation to wait-times.
  - A two tier system exacerbates multiple wait-lists. The British experience has not been good with a public and private mixed model.
  - Although private interests may be able to establish a health clinic quicker than their counterparts in the public system, the existence of such a clinic creates several problems. First, it lures precious health care workers, in particular nurses, away from the public system where they are desperately needed. Second, depending on the clinic's contract, its existence could compromise the effective management of the wait-lists of doctors who practice in both public and private

facilities. Finally, a privately run surgical centre will likely serve only low risk patients, leaving the more complex and acutely ill patients for the public system to care for. Yet if the private clinic is paid the standard rate per case, the public system could end up overpaying the clinic for its services.

- Doctors sometimes cancel procedures to work for profit or wait a long time before ordering tests, even when the person has been having symptoms for months or sometimes years.
- People are often told by doctors that they can have their surgery done sooner with the same doctor if they pay for it.
- Privatization is not the way to go to shorten wait-times. No matter if it is private or public there are not enough doctors to supply either system.
- Countries that have gone to a private system have reported that the quality of care has declined.
- Removing the ten people from the public waiting list may make the public list shorter in numbers, but it does nothing to shorten the wait-time. The doctors will service their private clients first and then spend their remaining time on the public clients.
- My daughter has been going to physiotherapy for months and is in pain while waiting for a Magnetic Resonance Imaging (MRI) test to diagnose her injury. There is a wait of three to six months for Magnetic Resonance Imaging (MRI) through the public system, but it is available the next day through private care if you have $1,200.
- Private clinics only do elective surgeries, not emergency surgeries. This means that patients do not get bumped to make way for emergencies.
- Several European countries have shorter or no wait-lists with excellent outcomes at lower cost per capita than Canada.
- One key issue to wait-times involve patients who do not attend appointments and who cannot be effectively charged for the time wasted. One doctor's wait- lists are several weeks longer than they have to be because of patient no-shows. There should be a penalty to teach people the value of these free visits.
- Private care is queue jumping and makes other wait-times longer.
- Wait-lists are being used as a ploy by government to introduce private care.

Ideas and Suggestions

Capacity
Costs and Funding
Health Care Models

- Ideas about capacity:
  - Audit hospital clinics as many are operating far from capacity.
  - Build more public surgical centers to decrease surgical wait-lists.
  - Dedicate operating room time to orthopaedic surgery.
  - Provide more medical support for long-term care facilities.
  - Increase access to areas and facilities that are currently underutilised.
  - Allocate a specific building to be used for intermediate care in transitional beds.
  - Create more access choices such as more walk-in clinics.
  - Provide more operating room capacity and more surgeons, nurses, health professional support staff to reduce wait-lists.
  - Provide more emergency and operating room staff.
  - Increasing capacity is not the only way to reduce wait-lists and narrow the gap between available capacity and demand. We also need to focus on areas to increase efficiencies, develop plans to do things differently, develop different scopes of practice or care plans, and reduce demand by preventing disease or by improving quality to reduce complications.
  - Run diagnostic and imaging equipment at full capacity 24 hours a day.
  - Reduce wait-times by investing in infrastructure to build more operating rooms.
  - Upgrade medical infrastructure in local communities such as Vancouver's downtown area to help alleviate wait-times for tests.
  - Increase the available operating room time in the Fraser Health North Region.
  - Allocate one hospital in certain areas that is just for surgery. That means no Emergency Department, palliative care, patients or anything else that exists in a normal hospital setting. This hospital would be just for doctors to operate and perhaps have some wards where patients could spend some recovery time before being moved to other hospitals if more recovery time is required.

- Ideas about costs and funding:
  - Speed up the process for surgery and provide appropriate funding allocations.
  - Provide more public sector hours to reduce wait-times even though this may increase costs for labour and resources.
  - Establish a Health Access Fund to enhance the portability of care for patients and their families by reimbursing the cost of care when services are not available provincially within the accepted wait-time benchmark. Such a fund should be created to support patient care costs as part of the introduction of wait-time benchmarks.
  - The Government of British Columbia is not looking at the big footprint cost of providing health care. For example, a teacher that requires surgery has a nine week absence for convalescence. For this absence, the school board is required to post a temporary position to replace the teacher, interview candidates, hire someone and then bring the successful candidate in to acquaint them with the students. Then, the teacher arrives for surgery only to have it cancelled so the whole posting, interviewing and hiring process is repeated six weeks later when the procedure is rescheduled. No cost to the health care budget, but certainly to the school board and taxpayer.
  - Work with the West Kootenays Health Endowment Trust that will be an investment and granting agency to fund health care services, projects and programs not financed by the British Columbia Government.
  - Properly fund and make available the latest and best diagnostic tools to reduce wait-lists, misdiagnosis and inadvertent death.
  - Support more local fundraising and grant applications to bring specialised testing equipment to smaller communities.
  - Fund the public system and reduce backlog as promised.
- Ideas about health care models:
  - Shorten wait-lists by creating one shop stops in the public system for common surgical procedures.
  - Reinstate the practice to send patients to other areas for treatment. For instance, years ago if a patient was on a wait- list for radiation they were sent to Bellingham for treatment and the medical plan paid for it.

- Development of a model for surgery that is like a mass-repair surgical assembly line would reduce wait-lists to almost zero.
- If wait-times are longer than one month, then people should be allowed to go wherever there are no wait-lists and the health-care system should pay for everything.
- Use private facilities to manage and/or reduce wait-lists.
- To improve wait-lists bolster existing operating room capacity in the public sector and consider more effective use of the private sector.
- Allow a mixed care model of public and private so people can pay for private care to shorten the wait-lists and free up funds for those who cannot.
- Establish concrete guidelines for queue-jumping and a paid or reimbursement referral plan to private facilities in the event of priority needs for scans that the public system cannot provide in a timely manner.
- Use the budget surplus to have the waiting list reduced by half, by contracting out any procedure that the patient agrees to have done to private clinics or the United States.
- To reduce wait-lists for a Medical Resonance Imaging (MRI) test, the Government should pay the fees to private clinics that have facilities available until the wait-list is shortened.
- Encourage the establishment of both private and public emergency clinics for non-life-threatening injuries so people with non-life-threatening ailments can get quicker care as they will not be bumped by more urgent cases.
- Expand the contracting out of daycare surgeries to private centers.
- Encourage a two-tier system to take pressure off the public system and allow for shorter wait-times.
- Open up pay clinics for specific surgeries. This does not mean that these surgeries would be taken out of the public health care system, but providing the option of pay clinics would ease a lot of hospital bed congestion.
- Create one stop shops for treatment, existing in Hamburg, which offer follow-up care at the time of treatment.
- Charge a no show fee to those who do not cancel scheduled medical test appointments if they are unable to attend.

- Maternity leave covers people for one year. Medical employment insurance should cover people waiting for surgeries in the same way.

Innovation

Comments and Concerns

Canadian Models

- Comments on Canadian models:
  - Alberta Hip and Knee Replacement Project, a joint effort by the Alberta Bone and Joint Health Institute, orthopaedic surgeons, health regions and the Alberta government is a prime example of how relatively simple, common sense changes can solve seemingly intractable problems. The Alberta project combined elements of North Vancouver's North Shore Joint Replacement Access Clinic and the Richmond and University of British Columbia hip and knee reconstruction projects and adds even more progressive ideas. The project is now the standard of care for hip and knee replacement in the Calgary, Capital and David Thompson health regions, and three other regions have expressed interest in adopting the model
  - In April 2006, the University of British Columbia Hospital opened its Centre for Surgical Innovation, a $25 million, one-year Provincial pilot project dedicated to fast tracking patients for hip and knee replacement surgery. The Centre for Surgical Innovation is specifically geared to serve low-risk patients who have been on a waiting list for more than 26 weeks. The project has two dedicated operating rooms and 38 inpatient beds, and aims to perform 1,600 surgeries a year. As of January 2008, the Centre for Surgical Innovation had carried out more than 1,100 procedures
  - The Richmond Hip and Knee Reconstruction Project had dedicated funding of $1.3 million, which meant that the project had a full-time manager, equipment, research and evaluation tools, a newly renovated operating room and new operating equipment. Funding came from the Provincial Government, the Vancouver Coastal Health Authority and the Richmond Hospital Foundation. But as numerous health care analysts know, money alone cannot buy success. In this case, however, money combined with numerous surgical efficiencies did. Operation start times were staggered and scheduled between two rooms, so

surgeons could swing between rooms as their patients were ready. This allowed operating teams to complete eight joint replacements or reconstructions per day instead of six. Surgical procedures and clinical practices were standardized, eliminating previous idiosyncratic variations. The move also resulted in significant savings for the hospital as it could negotiate better deals on bulk purchases.

- The North Shore Joint Replacement Access Clinic exemplifies an effective way to decrease wait-times for hip and knee replacement surgery by focusing on the preparatory work that must be done before patients undergo surgery. As a result, the North Shore Joint Replacement Access Clinic has dramatically reduced wait-times both before a first surgical consult and before the surgery. The North Shore Joint Replacement Access Clinic is a one-stop, centralized booking service for pre- and post-operative appointments and procedures. It opened as a pilot project in May 2005 and is now a permanent facility at Lions Gate Hospital.
- Mount Saint Joseph Hospital is a 140-bed, acute-care, community-based hospital in East Vancouver best known for its multicultural approach to care delivery, especially for the city's large Chinese community. Over the past three years it has become renowned for a cataract and corneal transplant program that outperforms every hospital in the Province. By completing more than 6,300 procedures a year, the program has cut wait-times in half (from six to eight months to three to four months), with many patients having the procedure within 10 weeks. Because there is little variation with cataract surgery, it lends itself well to production-line efficiencies without loss of quality. A decision to invest in the best technology and in more equipment so that surgeons do not wait for tools to be sterilized, allowed them to immediately get up to speed.

Ideas and Suggestions

<u>Canadian Models</u>
<u>International Models</u>

- Ideas about Canadian models:
  - Follow the model in Saskatchewan that posts surgical wait-lists with the surgical care network.
  - Have more clinical trials to shorten wait-lists.

- Look to innovation in the public health system to improve service such as consolidating waitlists.
- The Ministry of Health should consider the nationally recognized best practices that the Vancouver Coastal Health Authority implements to reduce wait-lists.
- Create a centralized surgical wait-list system such as the Joint Rapid Access Clinics that were created in Alberta. These clinics engage people on wait- lists well ahead of surgery to improve their health and knowledge for better surgical outcomes and less acute care bed days. These clinics also support accurate, bare minimum diagnostic procedures done prior to seeing specialists.
- Contract out joint surgeries to the Fraser Surgical Clinic or other clinics.
- Public clinics with one stop service can decrease wait-times. For instance, there are breast health centres in Canada and elsewhere that perform follow-up tests immediately on the women who have positive mammograms.
- Follow Ontario that has an emergency patient referral system called CritiCall that allows admitting clerks, hospital administrators and even physicians to track beds, emergency department status and other medical resources. This allows for the direction of patients to facilities that can help them quickly and thus reduce wait-times.
- Ontario research is in the preliminary stages, but it suggests that there is little conclusive variation in impact among existing Canadian models. In other words, we do not know which model absolutely will produce the best care. But we do not have a whole lot of data either. We do know that some primary care systems in other jurisdictions have managed to achieve triumphs in access such as same day access in England, Australia and New Zealand. In this case, when you phone up for an appointment your chances of getting in that day are pretty high, and your chances of getting in within 48 hours are virtually 100 per cent.

- Ideas about international models:
  - Learn from the improvements that have been made in parts of Europe where progressive policies have substantially reduced wait-lists.
  - Learn about best practices on health care from the Netherlands.

June 2007

Submission to the BC Ministry of Health

"Conversation on Health"

FAMILY PRACTICE RECOMMENDATIONS

FOR

BRITISH COLUMBIA'S

HEALTH CARE SYSTEM

Society of General Practitioners of British Columbia

Society of General Practitioners of British Columbia

June 2007

Submission to the BC Ministry of Health
"Conversation on Health"

Summary

While it may be a cliché to say that health care in this country is in a crisis, the public quite rightly continues to complain: the average person has a tough time even finding a family doctor; most wait times for surgery, specialty consults and investigative procedures have increased; provincial health care costs continue to rise.

As governments confront these pressing problems, one key solution is often overlooked: Supporting and making better use of the family doctor (general practitioner).

Medical care delivered by family doctors is the foundation of our health care system. Unfortunately, this foundation is crumbling.

Numbers tell the story:

- Of the 30 most developed nations in the world, Canada ranks 26th for the number of physicians per population.
- More than 3.6 million Canadians and 150,000 British Columbians do not have a family doctor.
- Some 20 percent of B.C. general practitioners plan to retire or move within the next five years, and 80 percent are over the age of 40.
- The number of general practitioners providing maternity care has dropped to 20 percent of all GPs in BC.
- The majority of medical school graduates now ignore family practice in favour of specialty training. In the past, more than 50 percent of graduating medical students chose a career in general practice; today that figure has dropped to 29 percent making it their first choice.

The single biggest threat to the efficiency, effectiveness and sustainability of British Columbia's health care system is the decline in the number of family doctors and the failure of the health and education systems to recruit, train and retain family doctors to attractive, long-term careers.

The Ministry of Health's recent steps (2006 BCMA Agreement) to increase the remuneration of family doctors are positive and welcome. The Primary Health Care Charter, recently released by the Ministry of Health, is also a welcome attempt to formulate a long term vision for a strong and sustainable primary care system. The challenge now will be to sufficiently promote and strengthen these first steps in order to overcome the rapid aging and exhaustion of the family doctor workforce. The SGP believes that the proposed measures, as outlined below, are among the most effective and affordable ways that government can improve health care for all British Columbians.

Recommendations

1. Recruit and retain more family doctors

a) Increase the number of medical school seats and postgraduate training positions for Family Medicine.

b) Make changes to the selection of medical students to admit more applicants who demonstrate an aptitude for and interest in family practice.

c) Make changes in medical school curricula to maximise the length of the Family Medicine clerkship to encourage more students to choose family practice as a career.

d) Encourage more community family doctors to become involved in the education of medical students and residents by compensating them appropriately for their clinical teaching.

e) Attract more medical students to general practice by remunerating general practitioners at a rate competitive to specialists.

f) Attract more family physician graduates into practice by assisting them with the start-up costs of a new family practice.

g) Attract more medical students into Family Medicine with incentives to assist in reducing student debt load.

h) Provide more training for general practitioners to acquire the advanced skills needed to better serve patients in their communities. Remove barriers that prevent physicians from temporarily leaving their community practices to undertake this training.

i) Retain those general practitioners already in practice with a more substantial increase in compensation and annual increases thereafter for the rising costs of running a medical practice.

j) Maintain general practitioner involvement in hospitals and nursing homes by acknowledging the important contribution the GP patient relationship makes to the overall care of the patient.

2. Improve practice support for family doctors who care for patients with chronic disease, disability and terminal illness

a) Create ways to bring nurses, social workers, dieticians, mental health counsellors and other helping professionals into networks with existing family practices to make it easier for family doctors to coordinate multidisciplinary services for their patients.

b) Establish electronic connectivity standards for communicating patient information between family doctors, hospitals and other health professionals.

c) Subsidize the hardware and software acquisition and ongoing support required by family doctors to maintain electronic connectivity with hospitals and other health professionals.

d) Strengthen and build new community-based patient education programs that promote wellness, prevention, and chronic disease self-management. Ensure that community family doctors are involved in the planning and management of these programs.

3. Improve patient access to investigations, specialty care, supportive services and care facilities

a) Increase the availability of home nursing and home support services

b) Increase the availability of mental health and addiction counsellors

c) Encourage general practitioners to use all their expertise for the benefit of their patients by ensuring the availability of support staff, equipment and facilities for their use. This would include:

- increasing access to acute, rehabilitation, psychiatric and long term care beds
- increasing operating room capacity in community hospitals to reduce surgical wait times and to provide emergency obstetrical support
- increasing diagnostic imaging capacity (such as ultrasound, CT and MRI) in every region, removing barriers to general practitioners ordering these tests and using mobile and remote technology where possible to reduce travel for rural residents.

Background: The Value of General Practice

Proven benefits

The world-wide evidence is clear. Health systems with a strong emphasis on primary care are more cost effective. They also have better health outcomes and do a better job of providing health care to all socio-economic classes[2]. Nations with a high ratio of general practitioners to population have:

- lower per capita health care costs,
- lower rates of hospitalisation and medication use,
- healthier, happier populations, and
- lower mortality from lung disease, cardiovascular disease, and cancer[3].

People without a regular family doctor are 3.5 times more likely to end up in the emergency room[13]. In England it has been estimated that each additional general practitioner per 10,000 population is associated with a 6 percent decrease in mortality[4].

Superior Training

Primary care is complex. The general practitioner will see many patients who do not have serious disease. At the same time, he or she must be able to diagnose and treat rare disorders[6]. Being able to reliably distinguish signs and symptoms of benign conditions from more serious ones is a valuable and important skill that saves lives and saves money. With 10 years of training, the general practitioner is the best-trained health care provider to deal with the uncertainty and complexity of primary care.

Diversity of Skills

The broad training received by general practitioners allows them to provide a broad spectrum of care to people of all ages. General practitioners perform a wide variety of procedures including surgery, anaesthesia, midwifery and obstetrics, and provide emergency and trauma management. Their training enables GPs to provide mental health, preventative medicine, nutrition and lifestyle counselling[6]. The general practitioner is able to identify the health needs of the community and adapt to meet them in all these areas and more including:

- sports medicine,
- cancer therapy management,
- acute and chronic disease management,
- palliative care,
- geriatric care,
- home and nursing homes care,
- hospital services,
- comprehensive maternity care , and,
- emergency room work.

This flexibility and diversity of practice style is a great strength of general practice and should be supported and nurtured.

Team Leader and Essential Role in Primary Medical Care

There are four main features of primary medical care services:

1) first-contact access for each new need;
2) long-term person-focussed (not disease-focussed) care;
3) comprehensive care for most health needs; and,
4) coordinated care when it must be sought elsewhere[3].

The general practitioner is the leader of the health care team. With the patient, the family doctor chooses the most appropriate provider and coordinates the patient's overall care by the team members such as specialist physicians, surgeons, nurses, therapists, counsellors, and educators. Without the family doctor acting as coordinator, the care of the patient with complex needs can easily become fragmented. This puts the patient at increased risk of adverse effects. Studies in the United States that show that people who have a family doctor have better health outcomes[3].

Therapeutic Alliance
Over time, as general practitioners build long-term relationships with their patients, they are able to take the patients' personal, family and cultural values into account. This holistic doctor-patient relationship has been proven to maintain good health, optimally manage chronic disease, and hasten the recovery from illness and addiction. Patients who regularly visit a specific family physician receive more appropriate preventative care, have fewer diagnostic tests, receive fewer prescriptions, and have fewer emergency department visits and hospitalizations[3].

Advocacy
The general practitioner is a true advocate for the patient. This is increasingly important as our health and welfare system becomes more complex and costly. The long term relationship and therapeutic alliance that exist between GPs and patients means the GP develops intimate knowledge of an individual patient's needs. The GP can then use that knowledge to help the patient navigate the system and have those needs met.

Accountability
Physicians are held to the highest level of accountability. They adhere to the Canadian Medical Association Code of Ethics, and in B.C. their professional conduct is regulated and monitored by the College of Physicians and Surgeons of British Columbia. They are also subject to various Acts of the Federal and Provincial Governments and those who maintain hospital and nursing home privileges are subject to Health Authority Medical Staff Bylaws, Rules, and Quality Assurance Reviews. Physicians are also legally liable for meeting a reasonable standard of care. General practitioners continuously update their knowledge and skills, most through formal re-certification programs by the College of Family Physicians of Canada. Most importantly, the physician is ultimately accountable to his or her patient.

Maintenance of the Primary Medical Record
All health care providers keep a record of their interactions with patients, but the family doctor maintains the most comprehensive longitudinal record. This record is extremely important for the patient with multiple chronic diseases or complex needs. Appropriate consensual use of this comprehensive record prevents duplication of investigations and services and thereby benefits both the patient and the healthcare system.

Public Health Support
Family Physicians are often the first point of contact for the public when issues of public health are a concern. In addition to providing well child immunizations to a significant proportion of the population, family physicians support the public through general influenza immunizations and monitoring for first appearance of communicable diseases. Family Doctors were at the front line in the SARS outbreak and are the main source of information for the citizens of British Columbia when concerns arise about such illnesses as meningitis, whopping cough and influenza to name a few.

Educational Services
In addition, general practitioners are an important resource for public health advice and teaching, often serving on committees that monitor the quality of health care in their community. They are also involved in the training of medical students and Family Practice Residents in many communities.

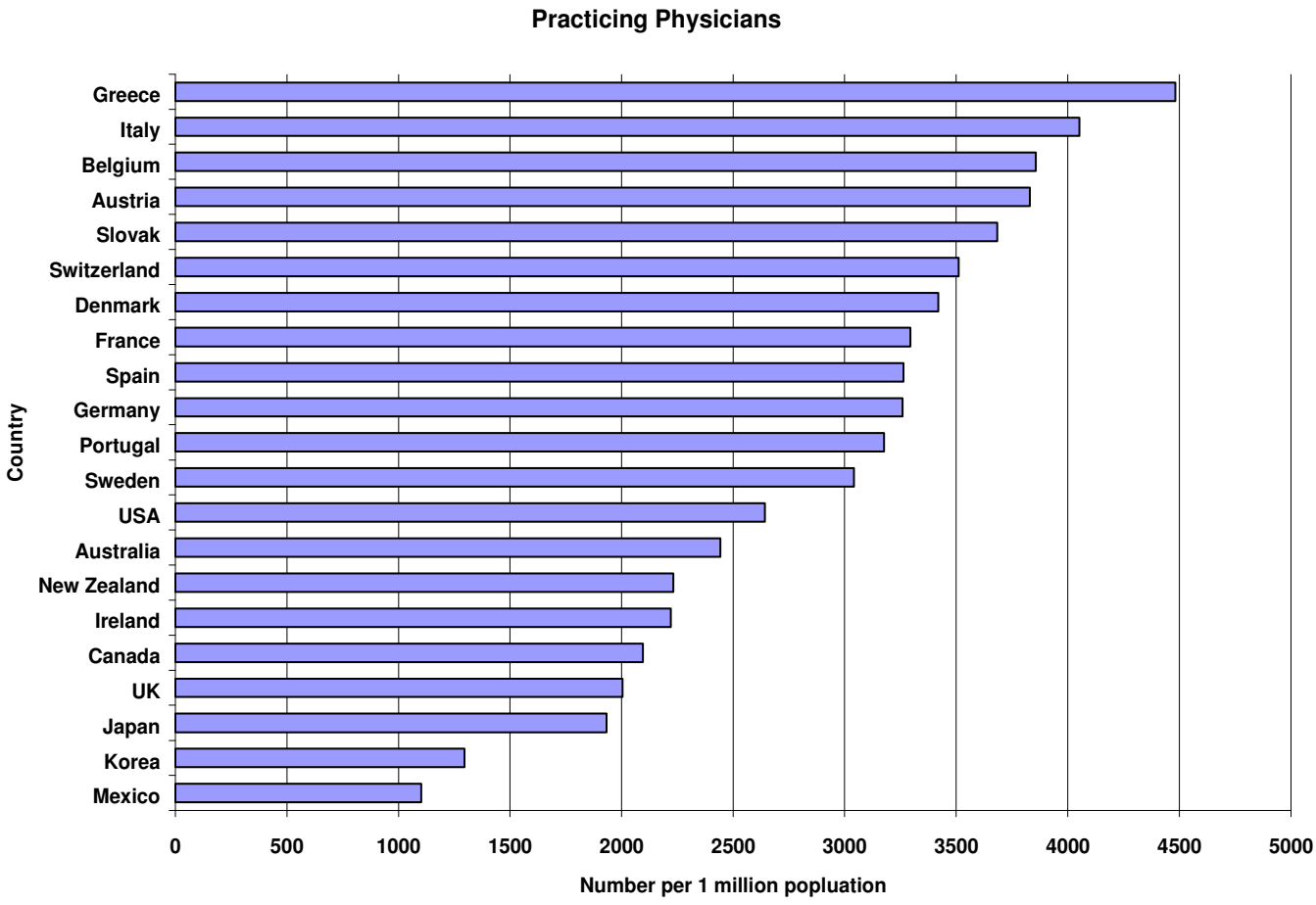
Supplemental Services
General practitioners provide many additional valuable services to their patients that are not considered "medically necessary" by the BC health plan (MSP) and thus the responsibility for payment lies with the patient or requesting third party. Some of these services include driver medicals, employment and insurance exams, wellness physicals, preventative health and life-style counselling, and completion of benefit forms.

Background: A Crisis in Numbers

Canadians rely on their family doctor for their primary health care. When surveyed, 85 percent say that they or an immediate family member have visited their family doctor in the last 12 months[12].

Unfortunately, this access is becoming increasingly difficult. Of the 30 most developed nations in the world, Canada ranks 26th for the number of physicians per population[5]. In 2003, 3.6 million Canadians did not have a family doctor and 1.2 million of these were actively looking for but unable to find one[1]. Fewer family doctors are accepting new patients now than five years ago[9].

Figure 1: Supply of physicians in OECD Countries from Simoens et al, OECD Health Working Papers, Organization for Economic Cooperation and Development, Jan 2006

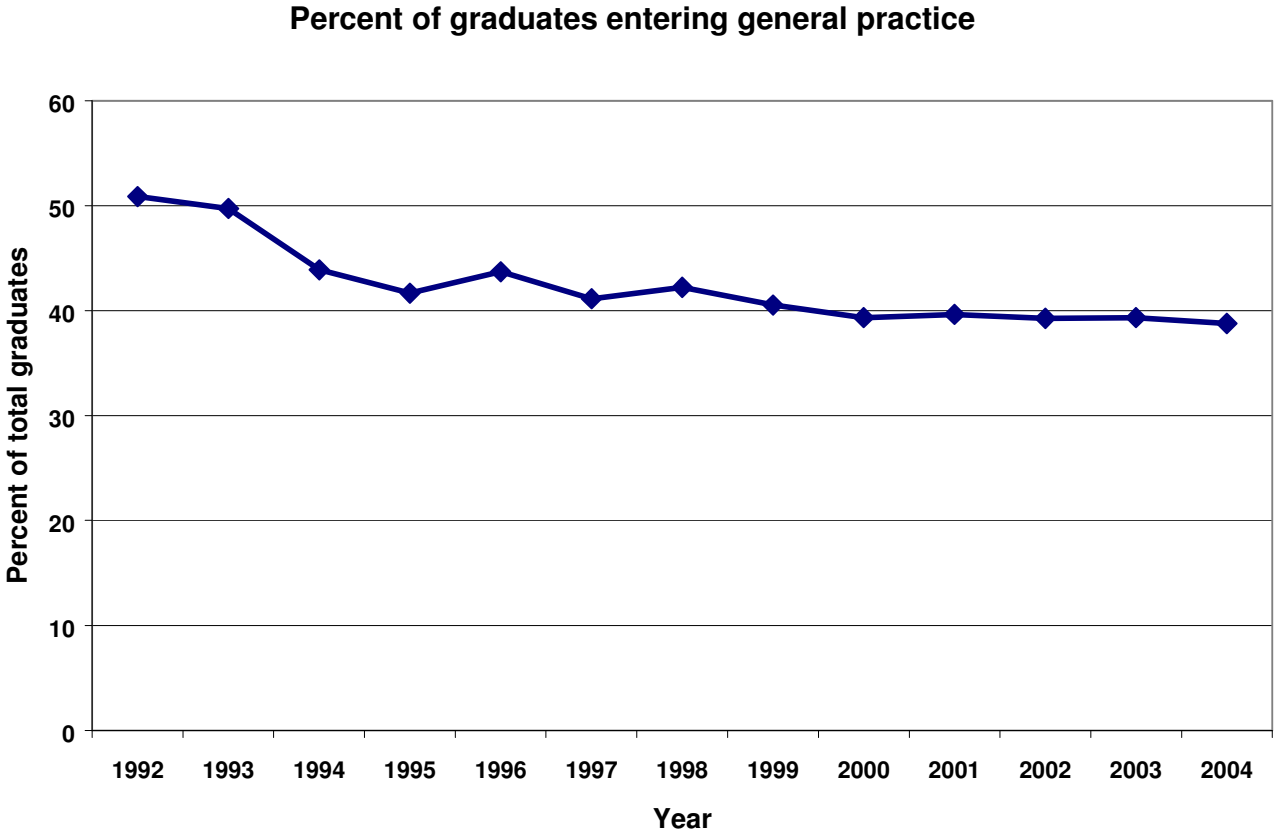


In British Columbia, 80 percent of B.C. general practitioners are over the age of 40 and 20 percent plan to retire or move within the next five years[7]. Many of those are unable to find anyone to take over their practices, leaving many “orphan patients." More than 150,000 people in B.C. are now without a family doctor and this number is growing.

Twenty years ago, more than 50 percent of graduating medical students chose a career in general practice. This proportion has declined dramatically over the last two decades. In 2007, only 29 percent of graduating medical students in Canada picked family medicine as their career of first choice[11]. In 2005, of the total 1,508 residency positions available for the first round of the CARMS, 930 were for specialty positions and 578 for family medicine. When these residents complete their

two-year family medicine programs at least 25 percent pursue other special interests rather than a career as a family doctor[10].

Figure 2: Number of new physician resident graduates entering practice from Canadian Medical Association Research Directorate "Physician Statistics" http://www.cma.ca/index.cfm/ci_id/40849/la_id/1.htm (Accessed March 2006)



Not only are there not enough general practitioners currently in practice, there is an accelerating retirement from the profession. Furthermore, as fewer medical graduates choose family practice, these physicians are not being replaced. It is the informed opinion of the Society of General Practitioners of British Columbia that the four main reasons for this are:

1) Inadequate remuneration
2) Difficulty accessing necessary care for patients
3) Increasing complexity of care, and,
4) Inadequate number of training positions

1. Inadequate remuneration

The costs of a medical education have increased dramatically in the last 10 years. Many students are incurring debts of more than $100,000 by the time they graduate. Subsequently, there is great financial pressure on students to choose a career path that will maximize their income.

The majority of Family Physicians in BC receive their majority source of income through “Fee-for-Service” from the Ministry of Health through the Medical Services Plan. Over the last several decades the BC Medical Services Plan (MSP) fee schedule, from which the majority of general practitioners in BC are paid, has failed to keep up with inflation. Time, intensity and complexity associated with an aging and growing population is only now beginning to be recognized with incentives developed by both the GP Services Committee and the Society of General Practitioners of BC. Because of rising

office expenses, rent and staff salaries the net income of office-based general practitioners has been declining. Meanwhile, the gap between the average billings of general practitioners and that of specialist physicians has progressively widened[21]. Consequently, a specialty career has more financial appeal to medical students than a career in general practice.

Many everyday services provided by the family doctor are only partially paid or not paid at all by the MSP schedule. These include:

- Coordinating the care of complex patients
- Accessing basic services for all patients,
- Maintaining comprehensive medical records,
- Provision of 24 hour community based on-call services, and
- Communicating with concerned relatives and caregivers of patients.

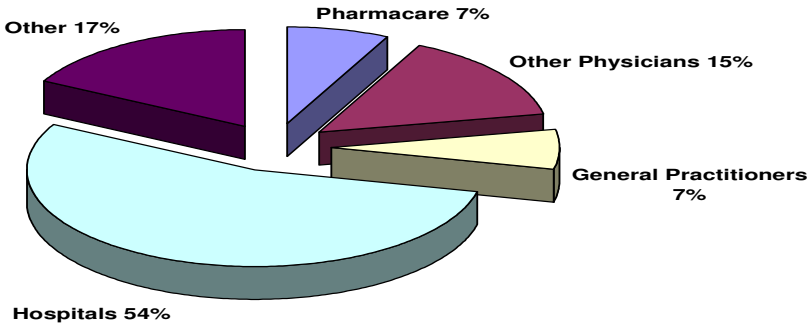
Consequently, general practitioners have been shifting their practice pattern away from this traditional type of care to less intense work such as the brief episodic care provided in walk-in clinics[10].

Recent targeted payments to general practitioners for the traditional type of care are appreciated but are still preliminary and not comprehensive as many areas of medical care are not covered under these targeted incentives. These new fees will narrow the gap between the average billings of general practitioners and specialists but it is too early to see if this will affect the retention of family doctors, let alone the attraction of newer graduates.

While there has been some move toward alternate payments (non-fee for service) for family physicians dealing with complex needs of select groups of patients there must be a link in the payment rates with the time, intensity and complexity of managing these patients in community clinics.

General practitioners in B.C. see more than 80 percent of the population annually and provide the bulk of primary medical care services in this province while expending only 7 percent of the provincial health budget[19]. Most of these patients never need to access secondary, tertiary or quaternary care. GPs can play a significant role in preventing chronic illness and maintaining the health of British Columbians and this would significantly reduce long term costs to the health care system. It would be faster and much less costly to further support existing primary care family practices rather than create a complicated new primary care delivery system.

Figure 3: British Columbia Public Sector Health Care Spending 2004 from Economics Department, British Columbia Medical Association, March 2006



2. Difficulty accessing necessary care for patients
The much-publicized problem with surgical wait lists frustrates physicians as well as patients, but these are not the only access problems. There can be unacceptable waits for investigative procedures like CT and MRI scans, and long waits to see specialist physicians, mental health counsellors, and others. In many cases the Family Doctor must provide specialized services and manage increasingly complex conditions while patients await assessment and recommendations. Rural patients may be additionally burdened by the need to travel long distances to receive services. Too often, the family doctor is required to search and negotiate through several layers of bureaucracy to get enough home support for patients, to find a long-term or acute-care bed, to obtain funding so the patient can afford his or her medication, or to arrange transfer to another city, province, or country for care that is no longer available locally. This often adds hours of work to the already lengthy day for the GP.

3. Increasing complexity of care
Our high standard of living, public health initiatives, and advances in medical care have combined to make us live healthier, longer lives. However as we age, we are more likely to develop one or more chronic diseases such as hypertension, heart disease, diabetes and arthritis that require ongoing medical management. When surveyed, 42 percent of Canadians report that they or an immediate family member suffer from a chronic illness[12]. Responsibility for coordinating care for these diseases appropriately rests with the family doctor, but this is complex and time-consuming work. Furthermore, pressure to achieve efficiencies in hospital care has resulted in shorter hospital stays and earlier discharge of ill and convalescing patients into the community without a concomitant increase in home nursing and support services. This has also greatly increased the family doctor's workload.

A commonly mentioned solution is for health professionals to co-locate to better provide care for patients as a team. Team based care is not a novel idea and family doctors have been doing it for years. There is some potential for improvement. When surveyed, physicians, nurses, and pharmacists agree that the inability to easily share information, their separate practice locations, the extra time required to communicate with each other, and the lack of financial incentives to do so can be barriers to optimal multi-disciplinary care[12]. However, information to date has not shown that co-location of providers is the answer. Enhancing communication of the members of the healthcare team can be done without requiring movement of members to the same physical space.

4. Insufficient number of training positions
This province and this country are not training enough general practitioners. The decisions by governments to reduce medical school admissions by 10 percent and reduce family practice residency positions by 30 percent because of recommendations contained in the Barer Stoddart report of 1991[17] are only now being recognized as mistakes. Recently medical school enrolments have been increased but there are still not enough medical student and post-graduate family medicine positions available. Canadian medical schools graduated only 1897 new doctors in 2005, not nearly enough to address the current gap. 1405 of these participated in the Residency Matching process with only 578 positions available to train Family Physicians for the entire country[11]. It is estimated by the BC Medical Association that BC alone needs more than 400 new physicians each year[20] .

Some medical schools consistently produce a higher percentage of general practitioners than other schools[12]. We recommend that medical schools make training family physicians a priority. Evidence shows that pre-existing aptitude and interest of medical school applicants are significant factors in their later career choice of family practice or specialty training. Furthermore students who undertake longer Family Medicine Clerkships during medical school are more likely to choose family practice. The conclusion is that a medical school that wants to train family physicians can increase its likelihood of success with a few simple changes: screen medical school applicants for their aptitude and interest in family practice and implement a family medicine clerkship of the maximum possible duration during medical school. At the post-graduate training level, the number of family practice residency positions should be increased relative to specialty residency positions. Furthermore,

creation of more re-entry positions for family physicians to return for specialty training would encourage more graduates to “try” family practice for a few years.

While advanced training of general practitioners in skills such as complicated obstetrics, Caesarean section, surgery, anaesthesia is necessary, especially in rural Canada[14,15,16], other skills such as endoscopy, palliative and geriatric care, addiction medicine and mental health are helpful in urban areas as well. There are currently only limited training programs available in some of these skills with those positions available often being difficult for practising family doctors to access.

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