

MEDICAL REFORM GROUP

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February 7, 2006.

Hon. Tony Clement
Minister of Health
Brooke Claxton Building, Tunney's Pasture
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Dear Minister:

The Medical Reform Group of Ontario (MRG) is a group of physicians and medical students who have been working, for over 25 years, to achieve and maintain high quality health care for all Canadians. We are writing now to present our perspective on possible health care priorities for your new government.

The MRG was delighted with your party's commitment to single-tier health care and the Canada Health Act that you personally expressed and vehemently supported during the recent campaign. Unfortunately, this commitment will be tested in the coming months. The previous Liberal government did not fulfil its duty to enforce the Canada Health Act against the extensive violations now going on in Alberta, British Columbia, Quebec, and Nova Scotia. In these provinces, patients can pay to get to the front of the line for imaging procedures such as MRI. Your government could demonstrate its commitment to the Canada Health Act by more aggressively reducing transfer payments as a penalty for these violations.

Ralph Klein's and Jean Chrétien's proposed legislation allowing private insurance for publicly insured services, and allowing physicians to work in both private and publicly financed systems, are gross, blatant, unprecedented violations of the Canada Health Act. We hope that you will soon speak out against this legislation, and bring the full weight of the Canada Health Act to bear on the provinces should they move forward. Your timely intervention before the legislation is passed could force these provinces to rethink their actions, actions which violate the fundamental principles of equitable health care.

We would also ask you to rethink one of your election promises. We understand that the intent of wait time guarantees is to relieve Canadians' anxiety over what they perceive as excessive, sometimes unacceptable, delays in health care. The guarantees, however, have two key limitations.

The first is that they make no attempt to address the underlying problems within the system. For example, Canada has the fewest practicing doctors per capita of any G7 country and we only maintain our above average nursing ratio by raiding third world countries. Guarantees will not train a single additional doctor or nurse.

Canada has so far failed to take full advantage of efficiencies that could shorten waiting times. The health sector lags far behind most other parts of the economy in utilizing computerized information technology for ready access to patient information.

We have failed to effectively apply queue-management theory. By and large, for instance, individual doctors keep their own waiting lists. Regional groups keeping a communal waiting list could facilitate quicker access

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Medical Reform Group, to Minister Clement, February 7, 2006.

to care. The government should greatly expand short-stay surgical clinics for procedures such as joint and cataract surgery.

Guarantees distract from the real task of implementing these efficiencies, and draw away resources that we need for innovation.

The second major problem with wait times is that they introduce what some have called "perverse incentives" into the system. Currently, doctors in Canada treat patients according to need. The sicker you are, the more you are suffering, the higher priority you have.

Guaranteed wait times introduce another factor into the decision - how long you have been on the list. That would be fine if there was a perfect one-to-one relation between need and length of wait. Unfortunately, that is not the case.

With guaranteed wait times, patients have a strong incentive to get on the list early, even if their problem does not warrant intervention at the time. After all, it might get worse, and once on the list, the clock starts ticking. Time on the list therefore tends to lose any relation to need.

For specialists, lots of quick short first appointments will ensure that patients get off the wait list before the required time runs out. Unfortunately, the process of actually sorting the problem out may lengthen interminably.

These two limitations - failure to address the underlying problem, and the perverse incentives they introduce - are the explanation for failed experiments with guaranteed wait times in Europe. Norway, Sweden, and Denmark have all tried and abandoned guarantees. Where they persist, they create an unhealthy tension between treating according to need, and treating according to time on the list.

It is important to distinguish between guarantees, which are likely to prove destructive, and wait time targets associated with rigorous monitoring. Setting guidelines for acceptable wait times, and keeping close track of how we are doing in achieving them, is highly desirable.

In Ontario, an easily accessed website will tell you waits for cataract surgery, joint replacements, CT and MRI scans, cardiac procedures, and cancer surgery in your region. This sort of monitoring is a big step forward. It allows a check on how we are doing in implementing the sensible, needed strategies and investment for reducing waiting times in publicly funded, not-for-profit delivered care.

We believe that your government should make a strong initiative to renew efforts to have provinces establish wait-time targets, to extend them beyond the areas they have so far established, and to rigorously monitor wait times and make them available to the public. We believe that this will be far more effective than guaranteed wait times, and avoid guaranteed wait times destructive consequences.

Thank you for considering the issues we have raised.

Sincerely,

A handwritten signature in black ink, appearing to read 'GUYATT', with a long horizontal line extending to the right.

Gordon Guyatt, MD