

Solutions for medical waiting lists – the right, and the wrong

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(Winnipeg Free Press Headline: Simple, appealing, and wrong)

“Need surgery, medical tests? Go to the end of the line.”
Find this message familiar? You should – you’ve been hearing it for quite a while. The Globe and Mail published that headline in 1989.

Two weeks ago in this column, I argued that much of medical care is discretionary – in other words, benefit is uncertain or marginal – and that rationing of care will always be necessary. Waiting lists are an inevitable by-product of a rationing approach that limits resources such as fancy equipment, operating room slots, and emergency room beds. That approach to rationing – the best available – asks doctors to attend first to those who need care the most.

I also pointed out that there are few hard facts about how many Canadians suffer important harm waiting for care. Nevertheless, surveys tell us many patients are distressed by long waits. Occasional stories of patients suffering serious consequences while waiting also suggest we have a real problem.

So what are the solutions?

The influential Kirby Senate report recommended governments set maximum waiting times for medical procedures. If the deadline passes, a patient could go to a private clinic in Canada or abroad, with the government picking up the tab.

This solution is simple, appealing – and wrong.

First, parallel private clinics will ensure waiting times stay long. Doctors running those clinics need to ensure patients are sufficiently frustrated by waits that someone – patients, insurers, or the governments – will pay for private care.

Second, a number of European countries have tried waiting time guarantees. The cure has proved worse than the disease.

Guarantees have not reduced the number of patients on the waiting list,

or average wait times. One reason is that as soon as the list shrinks, less sick or needy patients – the least likely to benefit – sign on.

More important, the guarantees focus excessive attention on those nearing what some have described as the ‘line of failure, shame and blame’. Doctors start to see patients approaching the deadline before they see new patients with more pressing needs.

Thus, wait time guarantees result in a set of perverse incentives. For patients, get on the list early, even if your problem is trivial. After all, it might get worse, and once on the list, the clock starts ticking.

For specialists, have lots of quick short first appointments to ensure patients get off the wait list. Unfortunately, the process of actually sorting the problem out may lengthen interminably.

All this runs counter to principles of sensible care. 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.

There are better solutions. First, we need reliable monitoring systems to determine the size of the problem. Such systems must not only count people waiting, and how long they wait, but also document their illness severity. We need this information to ensure that the effort to solve waiting time problem is in line with its magnitude.

Second, we must develop and apply uniform standards for acceptable waits for different sorts of problems. Evidence to date suggests that individual doctors apply widely varying criteria.

Third, we need regional systems to co-ordinate access to procedures with long wait times. This kind of co-ordination has allowed cardiac care in Ontario and breast cancer care in Britain to ensure the sickest patients get treated first, and to minimize administrative inefficiencies.

Fourth, at times we will require additional resources to, for instance, expand operating room slots, or build more MRIs.

These four strategies apply to waits for elective surgery and high-tech

diagnostic tests. What about emergency rooms, an area of ongoing controversy in Winnipeg?

Primary care reform with 24-hour access to family doctors' care may cut down on the walking wounded – those less sick patients with whom emergency room doctors can quickly deal. Because such patients require little time, reducing their volume will likely have limited impact on long waits.

Patients already seen and admitted to hospital, but stuck in emergency waiting for unavailable hospital beds, constitute a much larger problem in big-city emergency departments. These patients fill beds needed for new emergencies, and require considerable attention from nurses who are less available to care for new patients.

Expanded home care, and increased long-term care facilities, may keep the frail elderly in the community, and out of the emergency room. Or, we could reverse the long-term nation-wide trend toward reduced hospital beds.

These last solutions involve investing substantial additional resources in health care. That may be the right thing to do, but we should take care. It would be desirable to reduce inconvenience, and we would all feel better avoiding the occasional highly publicized horror story. But if that's all we achieve, the investment may not be worth it.