

Wait time guarantees are a misguided solution

This election gimmick fails to address underlying problems in the system and introduces perverse incentives for patients

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GORDON GUYATT

Conditioned by past disappointments, Canada's electorate will be watching closely to see if Stephen Harper keeps his election promises. Hampered by a relatively weak minority, Harper may have to pick and choose which promises he keeps.

Political parties are sometimes tempted to suggest policies that appeal to voters at election time, but fail the test of fundamental soundness. After the election, these policies — one might call them election gimmicks — are best shelved. One such promise that the new Prime Minister would be wise to dismiss is health-care wait time guarantees.

Wait time guarantees have the quintessential features of an election gimmick. They address a complex problem, and offer a simple, straightforward, appealing — but misguided — solution.

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 practising 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 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 is trivial. 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.

Some observers see a further risk in the guarantees. They worry that Harper's recent conversion to a believer in the Canada Health Act and equitable health care is insincere.

If so, could guarantees be an excuse for establishing investor-owned, for-profit facilities that would bail out current delivery systems when patients exceed wait times?

Strong evidence suggests — at least for hospitals and dialysis facilities — that for-profit care leads to poorer outcomes and higher charges for funders. Governments pay more, the public gets less.

That bad deal for Canadians could get worse if the clinics represent a step toward user pay American-style medicine. Harper's history suggests we should not dismiss this concern lightly.

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.

Shipping people to the United States or to investor-owned, for-profit clinics in Canada won't improve Canadian health care. Switching the criterion for moving from the front of the line from need to length of time on a wait list is bad for patients.

Harper's wait time guarantee promise is better broken than kept.

Gordon Guyatt MD is a professor of medicine at McMaster University and a spokesperson for the Medical Reform Group of Ontario.