

Demise of wait-time guarantees

It's no cause for regret

By Gordon Guyatt

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The federal-provincial health ministers conference last week, "Timely Access to Health Care," provided a showcase for progress in dealing with the highest profile issue in Canadian health care. It was also a demonstration of the profound hypocrisy that is now part of every government health care discussion.

The Harper Conservatives came to power touting a plan for wait-time guarantees. That plan is now in tatters. Of the provinces, only Quebec is interested.

Federal Health Minister Tony Clement had a deal with the provinces at the conference. You don't push for more money (which I am not going to give you), I won't push for action on wait-time guarantees (which you will refuse).

Fortunately, the slow death of the wait-time guarantees is a good thing. Guarantees result in a set of perverse incentives. Patients start getting on lists early, even if their problems are trivial. Specialists make many quick short first appointments to ensure patients get off the wait list. Unfortunately, the process of actually sorting the problem out may lengthen interminably.

Internationally, wait-time guarantees have failed. Norway, Sweden, and Denmark all tried and abandoned them. Where they persist, they create an unhealthy tension between treating according to need and treating according to time on the list.

Furthermore, many doubt Stephen Harper's conversion from two-tier health care advocate to medicare defender. They remember the federal health minister as "two-tier" Tony Clement who appeared before the Romanow Commission advocating for-profit health care delivery.

These skeptics see wait time guarantees as a Trojan horse for privatization. Private clinics will be the escape valve for waits, ultimately charging those who can jump the queue.

Skeptics will further point out the thriving two-tier care in British Columbia and Quebec, where patients can pay to jump queues for high-tech diagnostic imaging and out-patient or overnight surgical procedures. Both federal and provincial governments are turning a blind eye to these violations of the Canada Health Act.

Only when violations become outrageous does public opinion force governments to act. British Columbia Premier Gordon Campbell drew the line at a for-profit clinic charging patients for access to emergency room services. At the conference, Quebec Health Minister Philippe Couillard openly endorsed two-tier care. The other politicians ignored his declaration.

The lesson from the Supreme Court's Chaoulli decision is that governments cannot take a hard line defending universal access unless they ensure acceptable waits for those without the resources to queue jump.

Acceptable service within publicly funded health care is readily achievable, but it requires moving from rhetoric and spin to assertive action.

The conference did highlight some successes. Wait times in the key targeted areas -- including joint replacement, cancer care, cataract surgery, and heart surgery -- have been reduced. Reports of spectacular successes, including an Alberta experiment with facilitated referral and integrated care for patients possibly needing joint replacement, are beginning to appear.

But where are the political will and the resources to mobilize the medical system to replicate these islands of success in every major Canadian city? Health care worldwide lags behind other sectors in effective use of information technology and Canada lags behind other countries.

We don't even know for sure if Canadian doctors are right in their impression of increased waits in other areas as a result of the focus on priorities. Correcting the information technology deficit will require a national plan, with a major resource commitment. If the federal government made this -- rather than tax cuts -- a priority, it could happen and it could happen soon.

Isolated innovative programs have shown that application of queuing theory, common in other industries, can lead to major reductions in health care waits without large increases in capacity.

But major queuing innovation won't happen by itself. Governments must invest resources in quality councils to help health care providers in the application of queuing theory.

For the last decade, patients have suffered many-hour waits at emergency departments across the country. A big part of the problem is in the overcrowded hospitals that leave patients stranded in the emergency room waiting for a bed.

Where is the national home-care program that Roy Romanow's report demanded, that could keep the frail elderly in their homes and allow out-patient management of people who would otherwise require hospital admission?

Perhaps our federal government is serious in its commitment to medicare. Perhaps we will see a two-pronged effort with the leadership and resources for innovations that will see wait times become manageable, on the one hand, and, on the other, aggressive enforcement of the Canada Health Act. A government that replaced conference spin with real action would deserve a majority.

Gordon Guyatt is a professor of medicine at McMaster University, a spokesperson for the Medical Reform Group and a board member of the Canadian Health Coalition.