

Waiting for Health Care in Canada: Problems and Prospects

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A. Getting our Terms Right

1. What is a Waiting List?

A “waiting list” for health care is a list of patients awaiting a service such as surgery or an appointment with a cardiologist. But this doesn’t tell us whether everyone who waits for a service is actually on a list, or how patients get on lists, or whether they all need to be there, or who manages the lists. It is also silent on whether physicians share lists so that patients get service through the shortest or fastest moving list.

So when the *Winnipeg Free Press* reports that the wait list for cataract surgery in Winnipeg has 2000 patients on it, what does this tell us? Everyone can probably agree with the basic definition of a wait list. But that’s about all we’ll find agreement on in this contentious area. It is no wonder that we end up with a confusing public discussion about how long the lists are for different types of care in Canada.

2. Does Everyone Who Waits End Up On A List?

No. Take the case of Mr. Ross, who has seen his family doctor and will eventually be referred for an MRI. Before he finally gets his MRI, he may end up on half a dozen, or more, **different** wait ‘lists’ (for other specialty examinations; lab tests; x-rays; other diagnostic work-up; outpatient clinic; etc.). But he may also have waited a few days to see his general practitioner. Was he on a “waiting list” during that time? Well, no, or at least not a ‘formal’ one. The office appointment calendar is the wait list. No one in Canada keeps track of how many patients wait for appointments with their gp’s (is an appointment the same afternoon a wait?), or how long they wait.

3. What do people mean when they talk about “wait times”?

A “wait time” is the amount of time a patient is on a “wait list” before receiving the intended service or procedure. Even this simple notion gets complicated in some circumstances.

Let’s return to Mr. Ross awaiting the MRI. If he waits for four different physicians or services on his way to the MRI, at what point in that process should we start the wait time clock for the MRI? “Wait time” can mean the time Mr. Ross actually waited for the MRI, the time his internist told him he should expect to wait, the average or median time that all of that internist’s patients waited, or are likely to wait, and so on. Unfortunately “wait time” means different things to different people, can be calculated in many different ways, and is used for different reasons, often depending on the point being made.

Wait times can be either “forward looking” (prospective), or “backward looking” (retrospective). Each type of information will be useful to different people. It may be of some interest for Mrs. Fogg to know that her friend Mrs. Goodeye recently waited 4 months to have her cataract removed by an ophthalmologist in Regina. But it is more important for her to know that this ophthalmologist’s new cataract patients can now expect to wait 6 months. If she could get the

same information for all Regina ophthalmologists offering cataract removal services, she could make some important decisions. For those responsible for planning cataract facilities and services in Regina, it might also be useful to have the same sort of information on other cities in Saskatchewan, and indeed elsewhere in the country.

What's in a Wait?

4. How and when do patients get onto wait lists?

A typical process will probably look something like this: Mrs. Jones will see her gp, who will examine her and send her to a specialist (an appointment for which she may wait, even if she is not placed on a “wait list”). The specialist may decide (s)he thinks a CT scan is necessary to confirm a diagnosis, and will place Mrs. Jones on a wait list for the scan. Or he may decide that surgery may be necessary, and refer her to a surgeon who might, in turn, place her on a wait list for the surgery. That wait list will ‘belong’ to the surgeon.

Your doctor's decisions about when to put you on a wait list will depend on how urgent she thinks your situation is and how long the waits are for patients already on the lists. Consider Mrs. Fogg's cataract situation. Suppose that in her city, there is a relatively short wait time for cataract removal — say, 3 months. She sees her surgeon in February 1998. He notes that her visual acuity remains good, but a cataract is forming, and in a year or so it may warrant removal. Ultimately he puts her on the list in February 1999 and she has the operation in May 1999. Now suppose her twin sister has an identical visual situation, but where she lives, the expected wait time is 15 months. Her surgeon puts her on the waiting list in February 1998 in anticipation that she will get her cataract removed about May 1999. So both patients end up getting the cataract removed at about the same time, and end up waiting about the same time, but the “official” wait time will be 3 months for Mrs. Fogg, 15 months for her sister. This will be duly reflected in wait time statistics!!

Patients may end up on lists without knowing, or wanting, or needing to be there. In countries such as the UK, some wait lists are independently audited. Audits finding 20%, 30%, 50% and more of patients who should not be, and often should never have been, on the lists have been reported. Could the same be true in Canada? Embarrassingly, we don't know. Wait lists here are rarely (perhaps never) audited.

In short, patients get on wait lists in Canada through a poorly understood, haphazard, unaudited, entirely private process largely controlled by individual physicians. Do the needs of patients play a role? Absolutely. Is this the only thing that counts? We simply don't know. And at the moment we have no way of finding out whether two patients seeing different physicians for the same condition would end up on a list at the same time.

5. How are wait times measured?

“Wait time” is simply the interval between the point when a patient is placed on a list, and the point where she is taken off the list, either due to a change in her circumstances, death, or getting the service for which she was waiting. So if we take the average of the wait times for everyone

who came off a list last month, we will have a meaningful statistic on which everyone can agree. Right? Well, perhaps... but remember Mrs. Fogg and her twin sister. There are many different lists, many different points in a care ‘episode’ when patients might be put onto various lists, and many different decision rules used by physicians in choosing whether and when to place their patients on particular lists.

To complicate matters further, there are different ways of **measuring** wait times. Each answers a slightly different question:

- how long did patients recently treated have to wait for their service or procedure (**retrospective**);
- how long have patients currently on a list had to wait (**cross-sectional**);
- how long did patients placed on a list in January 1998 have to wait for their service or procedure (**prospective**).

There is no reason that these different methods will produce the same “wait times”. What’s worse, none of them provides a precise answer to the question most frequently asked by patients: “How long will I have to wait?” Using each of these three methods to provide an approximate answer to this question can, and often does, create a bewildering range of answers.

But even this is not the end of the story. The more statistically inclined will have noticed that we have been deliberately vague about wait time “statistics”. But here, too, there are choices. Which “statistic” the *Winnipeg Free Press* chooses to use can affect the impact of its message. Wait times tend to be, in statistical jargon, highly skewed. This means that very long waits are the exception. A few long waits can have the same misleading effect on wait time statistics as a few palatial mansions on average housing prices. If 11 patients have waiting times of 10, 15, 20, 15, 12, 8, 25, 60, 200, 15, 10 days, then the **mean** (average) wait time for this group of patients will be $390/11 = 35\frac{1}{2}$ days. Yet 9 of these 11 patients waited 25 days or less, and 7 of the 11 waited 15 days or less. When a patient asks that question, “How long will I have to wait?”, her physician is unlikely to say 35 days. Yet average wait times are often found in official wait list reports. Reader beware.

Only one of these cases is a candidate for a media story: the 200 day wait. We’ve all seen the headlines: OR backed up for 7 months. If we know nothing else about this case, we do know that such a wait is highly unusual. But in the world of selling papers and tv advertising spots, the exception often makes the story. This gets an unassuming public understandably concerned, playing nicely into the hands of those seeking to get more money into the system.

Is there a better way? In fact there are a number of more meaningful statistics. The **median** would be the wait of the middle, in this case 6th patient, if the patients are ordered by wait time – 8, 10, 10, 12, 15, **15**, 15, 20, 25, 60, and 200 days. Some reports use what we might call “range” statistics -- $\frac{1}{4}$ of patients waited 10 days or less; $\frac{2}{3}$ of patients waited 15 days or less, 1 in 11 patients waited more than 100 days, and so on.

As if issues of when, how and why patients end up on lists were not problem enough, there are other sources of variation behind wait time statistics. It is little wonder that much public confusion results.

6. Why do people disagree about wait times for the same set of patients?

Disagreement is a direct result of the many sources of variation noted above. Because choices can be made about when a wait begins (e.g. when Mr. Ross first sees his general practitioner, vs. when a specialist refers him for an MRI), how waits are measured, and what statistics are used to report wait times, it is inevitable that there will be disagreement about “true” “wait times”.

There are no agreed ‘scientific’ rules for when Mr. Ross or Mrs. Jones should be placed on a list. There is no ‘science’ that will tell us whether to use the retrospective or prospective method of measuring wait times. And while scientists may disagree about the merits of different statistics, all of them will be used at different times because different choices support different arguments. If you want to portray wait times as very long, you might argue that the wait begins with the point of first contact with a gp. This will provide a dramatically different picture than, say, using the time when a patient was booked for surgery. If you want to downplay the seriousness of the waiting game, you will cite typical waits and ignore the very long ones. Conversely, if you want to “demonstrate” that the system is falling apart, you will refer mainly to the few patients who wait a very long time, find an angry one, and parade him before the media.

7. Are patients on wait lists monitored and re-evaluated for changes in condition?

We don’t know. No doubt some patients are periodically reassessed. We have noted above that there is no requirement in Canada for wait lists to be independently audited to determine whether everyone on a list needs to be there. If even this minimal quality control is rare, systematic monitoring of the condition of patients on waiting lists — particularly for elective procedures — is likely also to be the exception. Remember that individual physicians — not hospitals or regional health authorities — create and maintain most waiting lists in Canada. Shared, coordinated wait lists managed by groups of physicians or hospitals are very rare. We know of no public information that could tell us whether, or when, the **order** of patients on lists is monitored and changed as a result of changing clinical circumstances.

8. What makes a waiting list fair or unfair for the public?

A core principle underpinning Canadians’ faith in, and expectations of, their health care system is “to each according to his/her need.” The expectation is that equal needs will be treated equally, and unequal needs differently. A wait list or wait list system that fails to ensure that patients get care roughly in order of relative need or urgency, would likely be viewed by most Canadians as inherently unfair. At least part of the current controversy around workplace injury victims receiving care faster than other patients awaiting the same services is based on a sense that this is unfair (although it may make perfect sense to a Workers’ Compensation Board and to employers).

9. What makes a waiting list fair or unfair for providers?

Health care providers are also directly affected by when and whether their patients get onto lists, and how long they have to wait. Let’s assume that cataract operating room time is assigned to

ophthalmologists on the basis of how many procedures they did last year, or the length of their wait list. Is this fair to providers, to their patients, to the public more broadly?

As potential or actual patients, we have an interest in ensuring that all physicians are sufficiently busy to maintain their skills, that new doctors have the opportunities to perfect and maintain those skills, and that our access to care is not jeopardized by the departure or retirement of a few providers. It would be unacceptable to interfere with the public's freedom to choose their doctors, but it is impractical, and undesirable, for all patients to be seen by the doctor with the biggest reputation. Providing the public and referring general practitioners with information about the track record of all providers (procedural report cards, for example) and differences in waiting times might lead to different choices and, quite possibly, shorter waits for at least some patients. Fairness to providers requires a careful balancing of the interests of **all** providers, not just those who argue that their long lists are a reflection of superior quality. This, in turn, begs for comprehensive and accessible information on wait times and on outcomes.

10. Who is responsible for the accuracy of wait lists?

In two words, “individual physicians”. With the exception of some cancer registries and cardiac care networks, there is very little coordination or sharing of wait list information among physicians. Physicians own the lists, and only they are in a position to be responsible for the accuracy of the lists.

But what makes a list “accurate”? Decisions about when it is appropriate to place a patient on a list are largely the decisions of individual physicians. If physician A places Mr. Ross on his list before physician B would have, does that make physician A's list “inaccurate”? physician B's? If an independent audit would find that Mr. Ross is inappropriately placed on a list, does this make the list “inaccurate”? There can be no answer to these questions unless there is widespread agreement on the “right” criteria for placing a patient on a list.

There are also other less contentious sources of inaccuracy. If patients end up on lists without their knowledge, and do not wish to be there, those lists are inaccurate. Similarly, if you have received your MRI but remain on a list, or you are on more than one list for the same procedure simultaneously, these are clearly sources of inaccuracy. Since wait lists in Canada are not audited, no one, including physicians themselves, has any idea how accurate Canadian wait lists are.

11. Why do some people seem to wait forever for service while others hardly wait at all?

There are many reasons why wait times vary. Some regions have fewer physicians or diagnostic machines per capita than others; if needs are the same, waits will tend to be longer in those regions. Some physicians “list early” in anticipation of long waits — recall Mrs. Fogg's sister. Some patients insist on being served by Dr. Longwait even though the services of Dr. Quick are available in half the time. And because most wait lists aren't managed in the true sense of the term, some unfortunate patients languish on lists because no one is paying attention and they are unassertive about getting something done.

But it's not always "the system" that makes people wait. British studies have shown that many patients refuse offered slots, choosing to wait longer. In Saskatchewan large numbers of people were found to have cancelled their own scheduled cataract surgery for reasons of personal convenience. "Waiting forever" (which usually means a year or two) is actually what some people want.

Patients awaiting different types of services are also likely to wait different lengths of time. Where a variety of surgical procedures all use the same operating rooms, some of those procedures (e.g. hernia operations) may be considered more elective than others. This will mean that hernia patients may wait longer than patients awaiting other procedures.

12. How can patients find out if other physicians have shorter wait lists?

- ask either their gp or specialist. But most of us would not do either, for fear of seeming to be questioning the physician's judgement, or because we want a particular physician to provide the service. In most situations the physician would not have the information anyway.
- check an internet or telephone-based wait list registry such as those in BC and Quebec. This has considerable potential. At the moment, however, there are concerns regarding the timeliness, accuracy and completeness of such sources. For example, they may not include all hospitals, or all services/procedures. In addition, most patients are unaware of their existence. Even if a patient does consult such a list, and finds a physician with a shorter list, at the moment the only way the patient can get other information on that physician is to ask his/her own physician; see above.
- in isolated situations, count on a well-managed registry such as the cardiac care network in Ontario, in which case they may not need to find out. One of the key purposes of such networks is to attempt to get patients to surgery roughly in order of urgency. Sometimes this means moving patients to the next available convenient source of care if their local system is backlogged. But even that network reports some variation in wait times across participating sites and providers.

In summary, at the moment it is virtually impossible, or at least highly impractical, for most patients in Canada to get this information.

13. Are Wait Lists or Times too long in Canada? How would we know?

The number of patients on a wait list is not meaningful, if it is not accompanied by information on how long they have been on the list. "Health care wait list 10,000 and growing" might make for great newspaper headlines. But if we are given additional information that the list is for patients with a non-life-threatening condition, and that the usual wait is 10 weeks, the situation takes on a different complexion.

We can't say if patients wait too long unless we define what "too long" means. This in turn requires a) consistent methods for deciding when patients should be placed on lists; b) that patients on the lists be ordered according to relative priority; c) periodic re-evaluation of their conditions; and d) mechanisms to move people up or down the lists depending on their changing conditions. Other than for some life-threatening conditions, the great Canadian wait lists tragedy is that we do not have the management or information systems to know, or to be able to find out

whether, and where, wait times are “too long”. What we have, instead, is a virtually endless litany of claims about dire circumstances. Where there are genuinely dire circumstances we can’t determine whether they arise because of too few resources, poor coordination or list management, sudden unpredictable changes in clinical condition, or any other reason.

14. Don’t people get sicker, and even die, while on wait lists in Canada?

Patients on wait lists can be in pain, have reduced mobility, and suffer anxiety. Their condition may deteriorate, sometimes to the point of making it impossible to have the intended procedure. Some patients on wait lists will die, just as sick patients not on wait lists die. Do patients die **because** they are on lists for too long? Are they more likely to die because of waiting than from undergoing the services/procedures? Does “the system” make too many people endure an “unreasonable” amount of suffering or risk?

It would obviously be desirable to have “suffering thresholds” below which we would expect people never to fall as a result of waiting. To eliminate all suffering due to waiting would require wait times of zero, the achievement of which would increase costs enormously. . The challenge is to balance the quite understandable concerns of patients awaiting care and their families, with the broader collective interest in ensuring that resources are used wisely and fairly.

Some recent Canadian research has found that not all patients are unhappy about waiting. Very few patients who felt waits were “too long” wanted to see additional public funds used to reduce wait times (although this may be related to the procedures they were waiting for and may also now be changing, as Canadians seem increasingly concerned about access to care). Fewer still seemed interested in shelling out extra money personally to reduce their wait time.

Claims about patients dying **because of waiting too long** cannot be confirmed or denied from current research and information. This is a part of the sorry state of wait list information in Canada. Even simple statistics such as deaths from different procedures, or deaths of patients on different lists, are simply not available.

15. Is Waiting always Worse than Not Waiting?

In a word, **no**. Some physicians put patients on wait lists knowing that the patient may need the service/procedure eventually, but where providing immediate service would be inappropriate. In some cases an alternative approach may improve the patient’s condition, in which case being put on a waiting list is a type of insurance policy. Waiting can also provide time for the patient and his/her family to seek other opinions, time for the body to have another chance to work its own magic. Indeed, the extensive audit research from the United Kingdom reveals many wait list patients who said they no longer wished to be on a list because their condition had improved.

B. Doing Something about Wait Lists in Canada

16. Why do we have waiting lists anyway? How come the United States does not?

Wait lists are a necessary part of managing a largely publicly funded health care system. If no one ever waited, key parts of the system (people, facilities, equipment) would sit idle for long periods of time because the system would have to be able to deal with ‘peak load’ demands. Or, worse, those ‘excess’ resources might be used to provide services of marginal, or no, benefit. The costs of this sort of over-investment can be immense, because we are preventing “real resources” (people, buildings, not money) from being used in other, more productive ways.

Wait lists (if appropriately constructed, monitored, audited, and coordinated) can be very useful management tools. As we have seen above, they are tools to get patients to resources in order of urgency/priority, give patients time for sober second-thought, and ensure that people, equipment and facilities are used efficiently.

We hear virtually nothing about wait lists in the United States because investment and training decisions are uncoordinated, and often private. The United States has ended up with much more capacity as a result. They have built, not by design but by accident, for peak load and more. Even public facilities are forced to compete with private; to do so they often buy equipment they do not really need, in order to “keep up with the Joneses”. The United States could be described as suffering from the side-effects of a medical equipment arms race.

But this doesn’t mean that patients in the United States never wait. The dirty little scandal there is that (approximately) 15% of the population has no insurance coverage. Many others have inadequate coverage, cannot get immediate access, and cannot move freely between jobs because of health care conditions. If you are sick in the United States and have either no or inadequate insurance coverage, you would probably consider being in Canada on a wait list a remarkable luxury. Such patients wait for care because they cannot afford it. They are not on anyone’s wait list, except their own.

17. What do other countries do to manage wait times?

The most common approach to reducing wait times has been to provide funding for additional resources (e.g. skilled personnel, operating suite time). But in country after country, research has demonstrated that additional funding has seldom permanently reduced wait lists or times. Indeed, sometimes more funding leads to more procedures, but longer waits. This “feedback” effect occurs because referring physicians increase referrals to specialists if they think wait times are going to fall. The implicit “threshold of need” for when to put a patient on a list falls.

Presumably because of the rather dismal record on reducing wait times by adding resources, some countries have paid more attention to the ‘demand’ side. One approach noted above is routine audits of lists. This has been shown to reduce substantially the number of patients on lists, but so far as we know has not, anywhere, become a mainstream, regular part of a wait list management system. Reducing the number of patients on lists could reduce wait times if some of those removed would otherwise have received the service inappropriately. Regular periodic

reassessments of patients on lists has also been used effectively in the UK to reduce last minute cancellations.

Some policies have focused on getting care to the patients who have been on lists the longest. One approach has been to arrange priority access for patients who have waited longer than a specified time. Another approach is to offer a “guaranteed maximum wait” time. Under this latter program, if the maximum wait time for an MRI is 3 months, and Mr. Ross has been waiting 80 days, he will be given higher priority than someone who has only been on the list for one month. Without additional resources to increase throughput, the logic of these programs is to deliver service to patients with less urgent needs (but who have been waiting longer) at the expense of patients with more urgent needs who have not been waiting as long. In contrast, the recently-developed New Zealand system ranks *all* patients on a list according to relative “urgency” and ensures that those at the top of the lists get care fastest.

A crucial point is that coordinated (or better, consolidated) wait lists have been found to be most responsive to the relative priority of patients. Some progress is possible even where individual specialists maintain their own lists if wait times are available to the referring gp’s, and they are encouraged to refer to specialists with the shorter wait times. Some jurisdictions have gone further, replacing waiting lists with a system of pre-arranged admission/service dates. Rather than being placed on a list and waiting until she reaches the top, under this system Mrs. Fogg would be given a firm date for her cataract operation. This has reduced the number of patients not showing up when called, and the number admitted through emergency departments.

18. What is being done in Canada to reduce wait times, and with what effect?

Canada has followed the international trend – the most common approach has been to throw money at the problems. But in some areas Canada has been among the leaders in developing coordinated list management approaches, an example being the Cardiac Care Network in Ontario. Such initiatives have, however, been the exception, not the rule. By and large, money has been used to paper over cracks, with little effort to find the underlying structural problems that created the cracks in the first place.

Other documents detail the approaches of individual provinces. Here we provide only the most cursory of summaries. Provinces have taken three general approaches: more funding; information enhancement (wait list registries); and coordination/priority-setting initiatives.

More Funding

Most provincial and territorial Ministries of Health have had to address perceived wait list/time crises at one time or another over the past five years. Targeted new funding has been the policy of choice. It is almost impossible to determine whether any of these injections has had long-lasting effects on the wait lists to which it was directed. Ministry reports in British Columbia claim that additional funding has reduced waits for some types of care. But any such effects are likely to be transitory, if international experience can be taken as a guide. Some provinces have developed contractual arrangements with care-providers in the United States, as a temporary measure to reduce pressure on in-province waits. These, too, have a mixed record of success.

Information Enhancement

British Columbia and Quebec appear to be the most advanced in terms of attempting to develop systems to provide timely information to referring physicians and their patients. Since 1993, the B.C. Ministry of Health has maintained a registry to track waiting lists and waiting times for many surgical procedures, covering about 30 hospitals and over 1,000 physicians. These data now feed a web site that can be accessed by anyone interested in wait times for different surgeons and procedures. Quebec has also recently established a similar web-based resource. Nova Scotia has recently provided a comprehensive report on wait lists and wait times and has plans to develop an ongoing wait list/time monitoring system.

Coordination/Prioritization Initiatives

Canadian initiatives to develop systems that co-ordinate the lists of individual physicians are few and far between. The leading example has been the development of the Cardiac Care Network (CCN) in Ontario. Twelve surgical centres participate in the CCN. Each centre has a nurse co-ordinator responsible for data collection and for locating a suitable and willing surgeon or interventional cardiologist who then communicates directly with the referring physician. If Mrs. Card is sent to one of these centres, she will be assessed and assigned a priority based on an “urgency rating score”. The CCN will then determine which site is able to provide her surgery in the most timely way. Similar patient prioritization systems are being developed and implemented in Ontario for orthopaedic procedures such as hip and knee replacements. There are other similar systems in pockets across the country, in cancer and eye care, largely because of the vision and commitment of individual or small groups of practitioners.

More recently, 19 partners in the four western provinces have teamed up in the Western Canada Waitlists Project. The intent of this project is to develop and field test patient priority ranking systems for five clinical areas – MRI, cataract, orthopaedic procedures, paediatric mental health, and general surgery.

To date, only the CCN has produced any information on “effects”. Research has shown that the priority rating schemes have been accepted by the physicians affiliated with the CCN, that patients with higher urgency scores tend to have shorter waits, that few surgeries get cancelled or delayed, that there are very few adverse events when patients are appropriately prioritized, and that waiting times are reduced if patients do not insist on a particular cardiologist. In this case, additional resources were also found to have led to a decrease in waiting times.

There appears to be growing interest in the further development of prioritization/coordination initiatives. Without them, in our view, there is little hope that Canadian provinces will be able to get beyond the endless crisis-cash-crisis... cycle.

19. Wouldn't putting more public funding into health care reduce wait times?

Not necessarily. If we don't have the information we need to determine where our real priorities lie, then simply adding funding for health care comes with no guarantee, or even likelihood, that the funding will get to where it is needed most. Should we put the funding into procedural cardiologists, or operating suites, or surgical beds, or cardiac perfusionists, or intensive care

nurses, or a program of flu vaccines for nursing home residents? If funding is handed out to those who make the most convincing sales pitches unsubstantiated by real data and analysis, then the public should quite appropriately be skeptical.

But even if we found the right targets, we would need to ensure that new funding got translated into additional “real resources”. Money doesn’t treat patients, nor does it inevitably buy increased capacity. If Ministries of Health add \$100 million to the system and it all goes for increased salaries for nurses (perhaps a good thing for other reasons), the money buys not a single additional procedure. If the cost of a drug doubles, doubling that drug’s budget will not make it possible to serve even one additional patient.

So should we ever add funding in response to apparent crises? Additional funding for health care is but one choice among many competing worthy aims, like preservation of parkland; salmon enhancement programs; better housing for inner cities; reduced class sizes, and so on. The first thing we should do is establish whether the *apparent* crisis is real, and what priority it should have, relative to others both outside, and inside, health care. Then we might well add money, carefully targeted. When we do decide to commit new funds to health care, we should not forget that we have many choices -- more paediatric mental health, or more cataract removals, or more flu vaccines, or more expensive drugs, or more hip replacements? Again, it will help to have information on expected costs and benefits since it will never be possible to do everything.

Part of keeping our eye on the ball is never forgetting the lessons of history. It does not matter how much public funding is made available to health care. There will still be claims that it is not enough, that there are crises here, wait lists there, physician shortages here, nursing shortages there. The claims have been with us at all times, and all levels of funding.

20. Why can’t I simply pay to get faster access? Wouldn’t the private funding reduce the waits in the public sector?

An elected official with half a million dollars in the bank complains about not wanting to die on a wait list. Advocates pressuring provinces to allow private hospitals claim that these will reduce wait times in the public sector. Such complaints and claims have been with us as long as those general claims that the system is “under-funded”. And they do tend to find a responsive audience, among the public and the media. But these turn out to be more common than sense, and seldom do real consequences, or real agendas, get exposed.

What does “paying for faster access” mean, and how would it work? One option would be to allow people to “buy their way to the top” of queues in the public system by paying user fees. No one is actually proposing this system in Canada because it so transparently violates a central premise of Medicare: ability to pay shall not affect access to needed medical services.

Another option is to allow private facilities to operate entirely outside Medicare, with individuals (or third party insurance) paying the entire cost of procedures. This option, the argument goes, would take well-to-do people out of the public queue, thereby moving everyone else up and reducing wait times. And we would still have the tax dollars of those who opted out to fund public services, just as we get tax dollars to support public schools from those who pay handsomely to send their children to private schools.

At first blush, this seems to solve a lot of problems. Unfortunately the blush fades quickly. Even “full cost” is not, in practice, full cost. For example, people now can purchase laser eye surgery from a variety of private vendors. But in those (admittedly rare) instances when something goes wrong, the public system bears the costs of ‘mopping up’, which can sometimes be substantial and long-term. While this example is of a service not covered by provincial health plans, the scenario would be the same for hip surgery as for laser eye surgery. If Canadians could purchase hip replacements or hernia repairs in Canada privately, the public system, under current arrangements, would pick up the costs of private procedures gone wrong. Those who speak of “full cost” NEVER mean that these additional costs should be included. So even the “full cost” option ends up being public subsidy of private decisions in ways that the public might not support. Certainly they have never been asked!

Furthermore, creating a “full cost” private payment option still requires those “real resources” – people, places and things. How would we create those private resources? One option would be for health care personnel to work partly for the public sector, partly for private patients. Where this arrangement exists, research from Manitoba, Alberta, and the UK reveals that public patients of physicians who work for both public and private clients wait **longer** than patients of physicians who provide care only in the public sector.

Another option might be to require health care providers to make a choice between public and private care. Just how having some of our surgeons abandon the public sector for the private could possibly shorten public sector waits is not immediately obvious, particularly if, as many of those making the argument claim, there is already a shortage of physicians, nurses, etc., in the public sector.

Could we not simply increase enrolment in health science educational programs to produce enough personnel to serve both the public and the private parallel systems? Yes, we could, but at what cost, and who would pay? All post-secondary education in Canada is highly subsidized by taxpayers. Would Canadians really support paying higher taxes to produce graduates who would serve only the well-to-do? Alternatively, suppose we were to charge students destined for the private system full fare (on the order of \$40,000 annually for medical students, probably \$15,000 for nursing students). Should we open this option to the not-so-talented children of the wealthy while better qualified Canadians are denied entry to training programs? And would this mean that students graduating from the public post-secondary system would be barred from practising privately?

Such approaches would begin to move us away from “service on the basis of need; payment on the basis of ability to pay (through taxation)” to “service on the basis of ability to pay; payment on the basis of need”. This is more than simply rearranging words on the page. It strikes at the very heart of the funding principles on which the last three decades of health care in Canada have rested.

21. Are there other things we can do to improve information and reduce wait times?

The first order of business is to create good information systems, based on standardized concepts and terms that provide real-time intelligence for decision-makers and the public. They must identify people at risk because of potentially excessive waits; ensure that patients are reassessed

when their circumstances change; and remove those whose clinical condition improves, who have decided to forego the procedure, who die, who move out of jurisdiction, and so on. They should get patients to care roughly in order of urgency. They should also follow patients after their service or procedure, so that we develop information on how different patients do after receiving care. For most procedures, the current Canadian “non-system” of physician-controlled lists not only makes it impossible for managers to manage, but also “puts patients last”.

While it makes sense to begin sorting out the system in a few areas in order to establish some basic principles and to test the process of prioritizing patients (as the Western Canada Waitlist Project is attempting to do), ultimately this road must be traveled by the entire system. Accessibility and prioritization are crucial to every type of health care service; piecemeal ‘solutions’ may compromise overall system integrity, continuity and fairness.

Improving information and reducing wait times in a systematic and sustainable manner will require movement on a number of fronts, including significant investment in wait lists information, the coordination of lists with patient interests as the guiding priority, the development and application of validated patient prioritization systems, and the implementation of independent random audits. In our view, all of these elements must be present if we are to see permanent gains and restored confidence among Canadians in access to care. As it is, the waiting list non-system in Canada is a classic case study of forced decision-making in an information vacuum. We have become hostage to our own failure to invest in the necessary intelligence-gathering.