

Patient Care Guarantees - A Discussion Paper by BC's Physicians

Background

BCMA policy advocates for an abandonment of attempts to explicitly define the term “medical necessity” as it relates to identifying those services that are insured under the medicare program and calls for a pragmatic determination of those services that will be insured, based not on clinical, but on economic and political grounds. In order for medicare to remain sustainable, governments must have the flexibility to determine those services that are “core” to the program.

The BCMA is also explicit that with that flexibility, governments must be accountable for their decisions; that timely access to those “core” services must be ensured. In a truly patient-centric system, patients must possess a clear understanding of what they are entitled to and when they can expect it.

Lengthy patient waits for medical care remain a matter of grave concern for the public. This concern has stimulated a discussion of the feasibility of introducing care guarantees for medical services (i.e., service guaranteed within a prescribed time frame). This idea was a featured element of the submission made by the CMA and its Divisions to the Romanow Commission.

Situational Analysis

Care guarantees already exist in a few countries. The U.K. has the longest record of guarantees, dating back to 1991, when the Scottish Office declared a 12-month maximum wait for treatment. This initiative was expanded to England in 1992 by way of a Patient Charter and, since then, there have been various forms of guarantees used by the NHS. The most current form, that replaces the Charter, is an NHS Guide (18 months for inpatient treatment, 26 weeks for outpatient treatment).

Sweden has supported care guarantees since 1992, initially by way of a 3 month surgical guarantee for twelve select procedures (in effect between 1992 and 1996). This guarantee was subsequently abandoned in all counties but Stockholm, where it is still applicable and reportedly well-received. Patients are able to obtain fully paid care outside the country if the guarantee cannot be met within the Stockholm county. The national program has been redesigned to apply only to visit appointments to GPs (8 days) and specialists (3 weeks).

Denmark has, as of July 2002, introduced a surgical guarantee, similar to the Stockholm model, but with a 2, as opposed to 3, month maximum wait.

Within Canada, these experiences were reviewed by both the Kirby Senate Committee and the Romanow Commission, who offered differing perspectives. Kirby supported the Swedish model of a rigid guarantee, including the ability to receive care outside the country, if necessary, at government expense. Kirby noted, “Since government has responsibility for ensuring the adequate supply of the essential services of hospitals and doctors, this responsibility carries with it the obligation to meet reasonable standards of patient service.” Romanow, however, rejected the notion of putting the patient first in favour of health system management stating, “...provincial and territorial health care systems need flexibility in managing these surgeries effectively. That flexibility could be lost if care guarantees were rigidly applied.”

At the provincial level, care guarantees have not yet been adopted in any jurisdiction. In 2001 the Alberta government received a report from their Premier's Advisory Council on Health, chaired by the Rt. Hon. Don Mazankowski, that advocated for a 90-day guarantee for selected services. Alberta has established an expert advisory panel to develop an implementation plan, however, to date no report has been forthcoming. The British Columbia government, on the other hand, is already on record as rejecting care guarantees, noting "Waitlist guarantees are impractical ... we say let's not spend extra money on unrealistic or arbitrary waitlist expectations."

From directions articulated in the 2003 First Ministers' Accord, it is evident that there is no widespread appetite amongst governments to provide for improved patient access by introducing care guarantees. In fact, the Accord does not mention the issue, nor even identify waiting times as an issue to be anything other than monitored. Not only is this a failure to demonstrate accountability on the part of governments, it reflects a shallowness in their stated objectives of putting patients first.

Governments' lack of interest has seemingly put them on a collision course with the medical profession. The CMA position on care guarantees, accepted by all of the Provincial Divisions, is very clear and supports the thrust of the Kirby and Mazankowski recommendations. It reads as follows:

- (a) That Canada's health system develop and apply agreed-upon standards for timely access to care, as well as provide for alternative care choices – a 'safety valve' - in Canada or elsewhere, if the publicly funded system fails to meet these standards.
- (b) That the following approach be implemented to ensure that governments are held accountable for providing timely access to quality care.
 - First, governments must establish clear guidelines and standards around quality and waiting times that are evidence-based and that patients, providers, and governments consider reasonable. An independent third-party mechanism must be put in place to measure and report on waiting times and other dimensions of health care quality.
 - Second, governments must develop a clear policy stating that if the publicly funded health care system fails to meet the specified agreed-upon standards for timely access to core services, then patients must have other options available to them that will allow them to obtain this required care through other means. Public funding at the home province rate would follow the patient in this circumstance, and patients would have the opportunity to purchase insurance on a prospective basis to cover any difference in cost.

On the Ground Activity

Notwithstanding the overall lack of interest displayed by most governments, public concern over excessive waiting times remains high. Recently released data from Statistics Canada's Health Access Survey (Canada-wide) indicated that:

- a) Between one-fifth and one-quarter of patients waiting for a specialist visit or non-emergency surgery reported that their wait time was unacceptable.

- the median wait for this group was 13 weeks, compared to a median wait of 4 weeks for those reporting an acceptable wait
- b) Approximately one-fifth of all those individuals waiting for care reported they were adversely affected by the wait.
- the main effects included anxiety, pain, deterioration of health, impairment to daily activities, and family stress
- c) Those who reported waiting times as “unacceptable” were more likely to report that waiting affected their lives (50% versus only 5% amongst those who reported acceptable waiting times).

Although not conclusive, these data would suggest that Canadians’ concerns over waiting for care does increase as the wait lengthens and that the acceptable waiting threshold for non-emergent cases may be somewhere between 2 to 3 months for a significant number of Canadians.

Public interest is further reflected in the November 2002 (pre-Romanow) polling by IPSOS. In that poll, approximately two-thirds of Canadians identified reducing waitlists as the number one priority for health care spending. Although the question focussed specifically on diagnostic tests, it is reasonable to assume that other procedures would rate high as well.

The most concerted effort at developing mechanisms to assist in managing waitlists is occurring through the Western Canada Wait List (WCWL) project. A partnership of medical associations, research communities, health authorities and governments, the unofficial WCWL mandate is to: “Improve the fairness of the system such that access to appropriate and effective health care is timely and prioritized on the basis of need and potential to benefit.” In Phase I of WCWL (complete), priority waiting scores were developed for selected procedures, designed to rank order patients based on urgency and potential to benefit. In Phase II (in progress), the project’s focus is on developing maximum acceptable wait times for the same procedures.

The WCWL project team sees the development of maximum acceptable wait times as an important piece of the administrative structure that would be necessary in order to manage waits more effectively. It is certainly essential to any long term success of a care guarantee initiative.

Through the WCWL work, some interesting data has been gathered. From Phase I, focus group testing made it clear that the public is very concerned about lengthy waits and that while they understand the factors that might lead to a wait, they are not prepared to accept an indefinite waiting period. In Phase II, the project has started to test the public’s willingness to wait in more concrete terms. Preliminary information suggests that, in general, patients are less tolerant of waits than are their doctors. In a group of over 200 patients awaiting hip/knee surgery, both patients and doctors were asked to record their maximum acceptable wait. These responses were then grouped by priority score using the WCWL tool. At the lower levels of priority, acceptable wait times were very similar between patients and surgeons, at about 12 weeks. However, at the higher end of the priority scores (more urgent), patients were much less willing to wait (4-6 weeks) than their surgeons would find tolerable (10 weeks). This suggests that emphasizing clinically based measures may not be where the primary focus of attention should be placed.

Issue Assessment

Although the benefits of care guarantees are positive in terms of providing a needed patient focus and engendering government accountability, implementation is far from straightforward. There are a series of issues that will need to be carefully considered and/or resolved before an efficient and equitable system can evolve:

1. Infrastructure: Most importantly, system capacity must grow. Waitlist issues are a by-product of capacity constraints. This includes all elements of capital resources; diagnostic equipment, beds, operating theatres, and therapeutic and rehabilitative tools, in addition to the required human resources to carry out treatment and pre and post care. We must move the entire system from a state of under capacity (designed to eliminate down-time) to one of optimal capacity, where treatment of patients from within their home region can be expedited, at the same time as “contracting” to provide care to patients from other jurisdictions. This requires both monetary commitments and human resource training programs.

2. Public/Private Interface: While capacity must grow, this growth need not be restricted to the public sector. Private sector facilities can be an effective means of providing additional services, however, government must establish clear guidelines for the role they wish the private sector to play. The private sector can respond rapidly and efficiently where there is a clearly stated objective. The options include utilizing a private facility under contract to a public agency, or restructuring the Canada Health Act so that private payment alternatives are permitted under certain well-defined circumstances.

3. Reorientation of Priorities: The public must demonstrate a willingness to pay for improvements in access and, at the same time, governments must commit to rebuilding the acute care system, ahead of other health priorities that involve population health, primary care and pharmaceutical programs. As noted, capacity growth requires funding commitments. Funding enhancements can occur by way of three basic means:

- (a) raising public revenue through the tax system,
- (b) permitting an increase in private, user pay, opportunities, or
- (c) reallocating existing public funds away from other applications.

4. Coordinated Waitlist Management: To ensure that the system is equitable and accountable, considerable standardization of waitlist management systems will be required. Each participating jurisdiction (inter-regional and/or inter-provincial) will be required to introduce a standard method of placing, tracking, and removing patients on their waitlists. In addition, regulated procedures will be required that will govern the guaranteed transfer of patients between regions and/or hospitals; clear guidelines will be required for the circumstances where a patient transfer may be refused.

5. Management Flexibility: The system will be required to adapt to the new kinds of pressures that care guarantees will create. Non-urgent procedures will be given a renewed priority under a guarantee and this will generate resource pressures involving more urgent cases. In these circumstances, greater management flexibility will be required in order to allocate resources within the new constraints. This flexibility will entail a requirement for physicians to hold privileges at multiple sites, an openness to share caseloads, and an ability to allocate available OR time in accordance with the procedural needs of the week.

6. Evidence Based Treatment: As the available resources become more scarce, pressure will increase on physicians to demonstrate that treatments are required and that intervention at a

particular point in time is appropriate . It may well become more difficult to initially place patients on a waitlist.

7. Patient Education: Accurate information concerning waitlist lengths and openings for surgery in available jurisdictions will need to be made available to patients, to facilitate them making a location choice in those cases where treatment is not available in their “home” location.

A Policy Platform for the BCMA

1. The BCMA supports the introduction of patient care guarantees for diagnostic, therapeutic and surgical treatments.
2. These patient guarantees must be rigidly applied. Where the designated service can not be made available to patients in the originally referred location and within the guarantee period, patients will be entitled to obtain treatment elsewhere, at no cost to them. Treatment could be obtained at another public facility in or out of province, or in a privately owned facility, in or out of country.
3. The BCMA recommends that a significant portion of the new federal health funding over the next three years be used to increase the capacity of the acute care sector, so that patient care guarantees may be managed.
4. The BCMA calls for the establishment of a Task Force consisting of equal representation of the provincial government (including health authorities and the Medical Services Commission) and the medical profession to develop a strategic plan for the implementation of patient care guarantees.
5. That patient care guarantees for all diagnostic, therapeutic, and surgical services be introduced by no later than January 1, 2005, and that they be introduced for a select group of services by no later than January 1, 2004.
6. That the BCMA re-affirm its support for the continuing work of the WCWL project in establishing maximum appropriate wait times for services.