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## Meeting the challenge of reducing waiting times for surgery

The article by Snider and associates in the current issue of the *Journal* (*Can J Surg* 2005;48:355-60) tackles the thorny issue of waiting for access to care in Canada's public health system. In their study, the investigators surveyed patients who waited for total hip or knee arthroplasty in both community orthopedic practice and an urban academic tertiary care setting. Significantly, over half the patients waited longer than 9 months for surgery. There was also regional disparity in access to consultation, with urban patients waiting longer. Patient acceptance was low: half the patients expressed discontent with the waiting time. Although objective measures of functional deterioration were not studied, overall 47% of patients perceived that waiting significantly contributed to a deterioration in their health.

This article is a timely reminder of the eroding confidence of the public, who believe their health care system is falling short of providing access to quality service in a timely fashion. A September 2004 "10-year plan to strengthen health care" identified this serious shortfall and recommended a multibillion dollar investment to reduce wait times by increasing the training of health professionals, clearing backlogs, building capacity, improving community care and developing tools to manage wait times. Five clinical areas of priority were identified: joint replacement surgery, cancer, heart disease, diagnostic imaging and sight restoration. An aggressive timeline for developing indicators of access for health care and evidence-based benchmarks for medically acceptable wait times has been

targeted for December 2005. What progress has been made?

Since the September 2004 proposal, 2 significant initiatives have moved us toward a more equitable system. The Association of Canadian Academic Healthcare Organizations (ACAHO), as a leader in education for new health professionals and innovation in practice through health research, reported a number of strategies to develop and implement solutions for preventing prolonged wait times in the publicly funded health service.<sup>2</sup> Particularly useful was progress in prioritizing patients for cardiac surgery, joint replacement or diagnostic imaging and the adoption of evidence-based urgency scoring tools such as those developed by Western Canada Waiting List Project and the Saskatchewan Critical Care network. A second initiative was a discussion initiated by the Wait Time Alliance (WTA), consisting of 6 medical specialties and the Canadian Medical Association, which reported provisional benchmarks for wait times by specialty, first principles for medically acceptable wait times and some subsequent steps for action.<sup>3</sup> On June 9, 2005, the Supreme Court of Canada released its historic decision on the *Chaoulli-Zeliotis* case for the importance of decreasing wait times for publicly funded health service. In August 2005 the WTA released its final report with strategies to improve timely access to care,<sup>4</sup> which goes a long way to addressing issues identified by Snider and associates and which has implications for surgeons.

Surgeons need to be active participants in the definition of wait-time

benchmarks. As far as possible these should be based on published evidence, but expert opinion is also essential. A proposal to develop a “wait time code” is sound advice. This sets out rights and responsibility for patients, providers and governments to provide timely quality care by accepting priority tools that define care based on need. In our health authority, this will be addressed by a rigorous resource allocation methodology, which defines access to clinics and operating room resources. Surgeons will need to work in teams to share wait-list information with others, to improve system efficiency and to monitor for deteriorating health conditions that necessitate faster access. The WTA also recommended a “4M tool box” of strategies to *mitigate* the need for wait lists (prevention), *measure* wait times, *monitor* wait times and *manage* wait times. Surgeons have reasonable expectations that health authorities will fully engage them by providing resources

to monitor and refine wait-time strategies based on this concept. Education of health professionals is a much-needed strategy to help reduce the obstacle of limited access arising from a shortage of such qualified professionals. This is no easy task since a system that is accommodating to greater service must also provide time to teach. A source of funds to recognize investment of this time must be sought. Finally, new knowledge and policy in wait-time management should be developed through research-granting agencies.

In summary, Snider and associates have reminded us of the challenges that lie ahead for surgeons to address unacceptable delays in therapy. There has been progress, but surgeons must work collaboratively with governments, other health providers and patients to establish fair, effective and timely access to their services.

**Garth L. Warnock, MD**  
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## Relever le défi de la réduction des temps d'attente en chirurgie

Dans leur article publié dans le numéro courant du journal (*J can chir* 2005;48:355-60), Snider et ses collaborateurs abordent la question épineuse de l'attente pour avoir accès aux soins dans le système public de santé du Canada. Dans leur étude, les chercheurs ont sondé des patients en attente d'arthroplastie totale de la hanche ou du genou dans une pratique orthopédique communautaire et dans un contexte de soins tertiaires universitaires en milieu urbain. Plus de la moitié des patients ont attendu plus de neuf mois leur intervention chirurgicale, ce qui est

significatif. On a constaté aussi une disparité régionale au niveau de l'accès aux consultations : les patients des milieux urbains attendaient plus longtemps. L'acceptation de la situation par les patients était faible : la moitié des patients ont manifesté leur mécontentement à l'égard des temps d'attente. Même si on n'a pas étudié de mesures objectives de la détérioration fonctionnelle, dans l'ensemble, 47 % des patients croyaient que l'attente a contribué considérablement à la détérioration de leur état de santé.

Cet article arrive à point pour rap-

peeler l'érosion de la confiance du public qui croit que son système de santé ne réussit pas à lui donner accès à des services de qualité en temps opportun. Dans le « plan décennal pour renforcer les soins de santé<sup>1</sup> » de septembre 2004, les premiers ministres ont cerné cette grave lacune et ont recommandé d'investir de multiples milliards de dollars dans la réduction des temps d'attente au moyen de la formation d'un plus grand nombre de professionnels de la santé, de l'élimination des retards accumulés, de la création de capacité, de l'amélioration des soins communau-