# Wait Times

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by Wendy Despins, President

On November 3, 2005, Dr. Brian Postl (Federal Advisor on Wait Times) addressed the Canadian Health Professionals Secretariat (CHPS) on his development of a strategic plan for national wait times. To date he has met with a large number of physician groups. "Benchmark Targets" and "Access Targets" are being determined and established. The "Benchmark Targets" will be recommended as federal standards and need to be significantly evidence based, whereas the "Access Targets" will vary province to province and will be based on physician experience in the absence of available research and data.

Dr. Postl identified the five priority targets of the wait time review:

1. Cancer
2. Heart
3. Diagnostic Imaging
4. Orthopedics (Joint Replacement)
5. Sight Restoration

Despite diagnostic imaging being identified as one of the five priority areas, Dr. Postl stated that no data exists that explicitly demonstrates the impact of diagnostics on the outcome for the patient, or wait lists.

Representing more than 70,000 health care professionals nationally, the CHPS delegates had a number of questions, comments and observations for Dr. Postl. After fielding many questions regarding wait times the group's sense was that Dr. Postl was not cognizant of the Professional Technical Paramedical impact on wait times. The following are examples of some of the questions the delegates posed to Dr. Postl:

- When is a patient on the wait list? When are they off the list? When does the clock start and stop for the wait time list?
- How will you ensure waits for post-surgical and rehabilitative care are part of the equation in assessing wait times?
- What about diseases other than the "big five"?
- How many wait lists is a patient on before and after a procedure is done, and how will these various waits be integrated into the overall question of how long a patient waits for care?
- What is the target date for establishing benchmarks?
- Do we have the health care providers to meet these targets? Where do you see the people we represent fitting into this discussion? *(In response to this question, Dr. Postl observed that these were interesting questions; and that health councils might have a role, but there were no specific plans to consult directly with our members at the moment.)*

With no plans for consultation in place, many questions remain:

- Given that 85% of all medical treatment is based on diagnostics, why are the critical shortages of the professionals who provide diagnostics not considered key to addressing long wait times?
- When provinces provide statistics indicating a reduction in wait times, are we confident these reductions are real? Or have patients gone elsewhere for service or simply removed themselves from the wait list altogether because they cannot afford to pay for the service?
- Is there a consensus on developing a single common waiting list? Has the issue of choice been taken into consideration?
- What is an example of an improved outcome based on a reduced wait? *(Dr. Postl's example of a benchmark target with evidence-based data was that of a hip replacement being set at 6 months wait or less had measurable improvement on the outcome and recovery for the patient.)*

The delegates suggested that diagnostics should be considered a factor in thereview of wait times. Dr. Postl thought that there are some real opportunities here for our membership to expand our scope of practice due to shortages amongst physicians and nurses.

A few days prior to Dr. Postl's presentation, there was a press release from Health Minister Tim Sale identifying the breakdown for the spending of the $155 million federal health dollars for Manitoba with some of that money, $25.5 million going for more diagnostic testing and $12.4 million to train health professionals.

Although physicians and nurses are an important factor in wait times and much has been done to address their impact, little has been done to address the impacts of the myriad of health care professionals involved with patients at varying stages, diagnosis, pre-treatment, post-treatment and therapy.

MAHCP believes that the clock on wait times should begin when a patient presents to an intake physician. The patient is often not referred to the appropriate specialist until results are back from diagnostic testing. Patients may wait from two to three and one half months for tests such as MRI, Ultrasound and CT scans.

Often the surgery is performed without adequate resources for post-surgical therapy. The clock shouldn't stop until post-treatment/surgery therapy is concluded.

There are also many other areas beyond the targeted five where wait times need to be addressed. In a meeting with the Acting Deputy Minister of Family Services, MAHCP raised a number of concerns including the wait times for children/pre-schoolers needing speech language pathology, and occupational and physiotherapy treatment through the Society for Manitobans with Disabilities. The wait time is currently eighteen months to two years and the program is only for preschoolers. Thus, if not diagnosed before two or three years of age, by the time a child is at the top of the wait list, they are too old to be seen in the program. This is unacceptable. It is well established that early intervention with a therapeutic team including Speech Language Pathologists, Occupational Therapists and Physiotherapists is crucial when working with these young children with a

range of disabilities from cerebral palsy, autism spectrum disorder, Down syndrome, global developmental delay, seizure disorders or other syndromes diagnoses.

Currently in Manitoba, Sleep Laboratory wait lists are over two years, and in order to have patients tested earlier, Manitoba will send a patient to Toronto for testing within three months. One can safely assume that this would be a significantly higher cost. While MAHCP applauds government's initiatives to expand the Sleep Lab program, even with the expansion they are not able to keep up, as the referrals continue to increase.

In late spring, MAHCP and MGEU made a joint presentation to the Minister of Health presenting statistics on critical shortages, recruitment and retention issues and training issues. MAHCP is pleased to see that several of the concerns we identified are being addressed by the Government, such as increased enrollment in training programs and improved enrollment standards.

Wait times are a very complex topic. They impact and are impacted by all aspects of health care. Wait times are affected by shortages throughout the spectrum of health care providers. Wait times evolved from human resource decisions made in the early to mid-1990's driven by government cutbacks and discontinuing of training programs. Wait times are currently affected by the under-funding of facilities to deal with the staffing shortages. There is capacity in the system for increased testing, but not the staffing to do it. A study of wait times needs to include a comprehensive look at the human resource requirements of all health care professionals.

There is a preponderance of evidence to support the tie between wait times and health care professional shortages. Even without a mass of statistics, one only has to go into an emergency room at a hospital, wait to be seen by a physician and then be sent for the tests required to make the diagnosis to understand that their wait time increases while waiting to be tested.

Across the entire health care continuum, the group that touches the patient in more ways than any other group in health care is the allied health care professional group. From diagnosis to rehabilitation, the allied health care professional will in most cases touch more patients in the course of their illness than physicians and nurses combined.

In order for Manitoba to deliver quality health care and reduce wait times, the human resource shortages of health care professionals providing diagnostic, clinical, pharmacy and rehabilitation services, together with improved physician and nursing distribution need to be addressed.