

## General commentary on access to cardiovascular care in Canada: Universal access, but when? Treating the right patient at the right time

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In 2004, the Canadian Cardiovascular Society formed an Access to Care Working Group with a mandate to use the best science and information available to establish reasonable triage categories and safe wait times for common cardiovascular services and procedures through a series of commentaries. The present commentary is the first in the series and lays out issues regarding timely access to care that are common to all cardiovascular services and procedures. The commentary briefly describes the 'right' to timely access, wait lists as a health care system management tool, and the role of the physician as patient advocate and gatekeeper. It also provides advice to funders, administrators and providers who must monitor and manage wait times to improve access to cardiovascular care in Canada and restore the confidence of Canadians in their publicly funded health care system.

**Key Words:** Health services accessibility; Medically acceptable wait times; Waiting lists; Wait times

Commentaire général sur l'accès aux soins cardiovasculaires au Canada : L'accès universel, mais quand ? Traiter le bon patient au bon moment

En 2004, la Société canadienne de cardiologie a formé un groupe de travail sur l'accès aux soins, dont le mandat consistait à utiliser les meilleures données scientifiques et la meilleure information disponibles afin d'établir des catégories de triage raisonnables et des temps d'attente sécuritaires pour obtenir des services et des interventions courants en santé cardiovasculaire, au moyen d'une série de commentaires. Le présent commentaire est le premier de la série et présente les enjeux reliés à l'accès rapide aux soins partagés par la totalité des services et des interventions en santé cardiovasculaire. Le commentaire décrit brièvement le « droit » à un accès rapide, les listes d'attente à titre d'outil de gestion du système de santé et le rôle du médecin à titre de défenseur des patients et de contrôleur d'accès. Il contient également des conseils à l'intention des bailleurs de fonds, des administrateurs et des dispensateurs qui doivent surveiller et gérer les listes d'attente pour améliorer l'accès aux soins cardiovasculaires au Canada et restaurer la confiance des Canadiens envers le système de santé subventionné par l'État.

### THE ISSUE

Canadians have clearly identified waiting times for medical care and diagnostic testing as a pressing issue that must be addressed by governments. In an annual survey performed since 1999, and most recently in 2004, less than one-half of Canadians surveyed were satisfied with health care access at home and in their community (1). In a recent poll commissioned by the Canadian Medical Association (CMA) (2), 49% of Canadians said that they or a member of their household had had to wait longer than they felt was reasonable to see a medical specialist. Thirty-one per cent of respondents felt that they had had to wait too long for diagnostic tests (up from 14% in 1999). Only 14% believed that Canada has an adequate supply of physicians. Clearly, there is increasing public angst about timely access to care.

Access to care has been a major focus of lobbying by the CMA and the Canadian Nurses' Association (3). These concerns are also shared by the cardiovascular physician community. In a survey of cardiovascular specialist physicians in 2001, the Canadian Cardiovascular Society (CCS) found that one-half of all surveyed cardiologists reported that patients had to wait five days or longer for a first visit with the specialist for an urgent consultation. For nonurgent referrals, one-half of the cardiologists reported that a patient had to wait eight weeks or longer for a first consultation. Fifty-two per cent reported that average wait times had increased in the previous year (4).

Improved access to care has become the rallying cry for those who wish to repair the tarnished reputation of Canada's health care system. Many have felt that the system is at a crossroads,

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and that funders, administrators and providers must ensure that the system is able to meet current and future projected needs.

### THE 'RIGHT' TO TIMELY ACCESS

An interesting legal battle is emerging that will define patients' right to timely care. While the third of the so-called 'five principles' of the 1984 Canada Health Act – accessibility – was not originally intended to address the issue of the timeliness of access (rather, it was intended to prevent discrimination on the basis of age, health status or income), the question of whether Canadians have a right to timely access under the Charter of Rights and Freedoms is currently being seriously considered.

The courts have not yet ruled that Section 7 of the Charter – which guarantees the right to life, liberty and security of the person – should be interpreted to mean that patients have a right to timely care in our publicly funded health care system, but many believe that the courts will eventually have to weigh in on the debate. The Senate Standing Committee on Social Affairs, Science and Technology, for example, recently stated:

*"...in the committee's opinion, the failure to deliver timely health services in the publicly funded system, as evidenced by long waiting lists for services, is likely to lay the foundation for a successful Charter challenge to laws that prevent or impede Canadians from personally paying for medically necessary services in Canada, even if these services are included in the set of publicly insured health services" (5).*

In June 2004, the Supreme Court of Canada heard an appeal in the matter of *Chaoulli v. Quebec*, where the plaintiffs claimed that certain provisions of Quebec's Health Insurance Act and Hospital Insurance Act are unconstitutional and violate Section 7 of the Canadian Charter of Rights and Freedoms. The impugned provisions prohibit private insurers from covering health services that are insured by the provincial health plan. The lower courts ruled that the impugned provisions do not contravene the Charter.

If the Supreme Court should allow the appeal and rule that timely access to care is a right protected under the Charter, the door to privately funded health care may be opened. The demand for a private tier of health care continues to grow and will not diminish unless governments demonstrate a commitment to the delivery of timely care within the public system with the necessary funding. Politicians, bureaucrats, managers, administrators and health care professionals are all highly motivated to address this problem.

### WAIT LISTS AS A HEALTH CARE SYSTEM MANAGEMENT TOOL

In the Canadian health care system, wait lists have been generally accepted, at least in principle, as one consequence of the rationing of health care resources. In fact, most providers would agree that an appropriately triaged and monitored wait list allows for the most efficient use of health care resources in a publicly funded system. Lack of a wait list, in fact, means that operating rooms and physicians are idle while waiting for the next appropriate patient. The keys to fair and legitimate wait list strategies include evidence and consensus-based criteria that aim to minimize adverse events. In addition, there must be measures to establish public confidence, assuring them that the system is transparent, safe and fair. There must be appropriate engagement of physicians, other health professionals, hospital administrators and government officials in the decision-making

process, and a rigorous monitoring system that tracks both individual and population outcomes – along with mechanisms to allow for positive change based on quality assurance feedback. Unfortunately, far too often, the status of individual wait lists reflected the level of investment that funders were willing to make in care delivery in that particular area rather than the demand based on medical appropriateness.

### THE PHYSICIAN AS PATIENT ADVOCATE AND GATEKEEPER

Wait lists become unsafe when they increase due to insufficient resources to meet the medically determined demand. This may relate to shortages of specialist physicians or to inadequate time or budgetary resources available in the operating room, or catheterization or electrophysiology laboratory. These resources must then be rationed among the patients who require them. The reality of fiscal constraints is that they will inevitably lead to rationing of services when there are not enough resources to provide the best treatment for every single patient or even most patients at the optimal time.

At the macro level, rationing decisions are made by health care funders (eg, government ministries) when they eliminate, reduce or underfund health delivery programs. At the 'meso' level, hospital managers create 'cutoff' points or 'ceiling limits' for some expensive programs. At the micro level, rationing is physician-based. This bedside rationing is defined by the following situation:

- the patient must be given less than the best available health care;
- the best health care must be withheld because of limited societal resources; and
- the physician must have control over the health care decision (6).

Physicians have traditionally been patient advocates. Indeed, the physician's fiduciary obligation to his or her patients has been firmly established by two decisions of the Supreme Court of Canada in the early 1990s (7,8). In contrast, there appears to be no corresponding legal duty on the part of a physician to act as a gatekeeper. A physician may not act as a gatekeeper when to do so would place the physician in conflict with his or her duty to the patient. The law is clear that a physician must act in the best interest of his or her patients at all times. All decisions made in respect of patient care must be made using sound medical judgment within the accepted standard of practice expected by a reasonable and competent physician in similar circumstances. In the event that the physician's duty to the patient conflicts with financial constraints within the health care system, the duty to the patient must prevail (9).

The duty owed by a physician to his or her patient includes three components, namely, the duty to provide care and treatment to the patient in accordance with reasonable standards of practice; the duty to inform the patient; and the duty to advocate on behalf of the patient.

The duty to inform a patient includes more than simply obtaining an informed consent, but has been extended to include the duty to inform patients of all available investigation and treatment options, whether available in the local community or elsewhere. The scope of the duty to advocate has not yet been fully defined in Canada, but would likely include the duty of a physician to take steps to reasonably

advocate on behalf of his or her patient to obtain the resources that are reasonably necessary to provide appropriate care.

While physicians are being asked, with increasing frequency, to take on the role as gatekeepers, this may place them in direct conflict with the legal and ethical duties that they owe to their patient. Physicians are finding themselves in a clinical and moral dilemma in which fiscal pressures may influence their decisions in ways that are inconsistent with a patient's best interest.

Physicians, both individually and through their professional organizations, have an important role in advocating on behalf of their patients and the general public to ensure that the policy-makers have the appropriate information and knowledge to make decisions regarding the amount of public resources that should be made available for the competing priorities within the public health care system. In addition, physicians and their professional associations have an important role in developing consensus within the profession and, where possible, appropriate guidelines and standards for the allocation and use of the limited health care resources.

Primary responsibility for the allocation of resources in the health care system should not be placed on physicians, but rather on those who provide the funds and determine where and how they are to be spent. If the health care system continues to underfund the delivery of care, thereby allowing fiscal considerations to outweigh individual patient needs, then funders must be prepared to acknowledge and defend this conclusion publicly, and to engage in the institutional design that is necessary for developing a legitimate and transparent process of rationing.

### PROVINCIAL SYSTEMS TO MONITOR AND MANAGE WAIT TIMES FOR CARDIOVASCULAR CARE

There are no national standards for access to cardiovascular procedures or office consultations. Some provinces have developed targets for some procedures (eg, coronary artery bypass graft [CABG] surgery, percutaneous coronary intervention and diagnostic catheterization), but these are not consistent across the country.

It is instructive to recall that the Cardiac Care Network (CCN) of Ontario came into being in the early 1990s after a patient died while on the waiting list for CABG surgery in Ontario. The political fallout at the time resulted from the perception that wait lists were not well managed. This led to the birth of the CCN. As a testament to the CCN's success, the CABG wait list mortality has been maintained at well below 0.5% (the benchmark) since 1997 through the implementation of an urgency rating score system and the establishment of recommended maximum waiting times (10) that are specific to each urgency rating score.

Governments and organizations in other provinces have initiated wait list projects as well, including surgical wait list registries in British Columbia, Quebec, Manitoba and Alberta; the Saskatchewan Surgical Care Network; the Nova Scotia Provincial Wait Time Monitoring Project; and the Western Canada Wait List Project.

### GOVERNMENT INITIATIVES TO IMPROVE ACCESS TO CARE

The growing public and professional concern about waiting times featured prominently in the last federal election campaign. Because it is a leading cause of death and disability

among Canadians, access to cardiovascular care was one of the priority areas identified by the federal government.

The First Ministers have agreed that clear public reporting on health system performance, including waiting times for key diagnostic and treatment services, must be a priority. In addition, the most recent First Ministers' Conference on Health Care established a \$4.5 billion Wait Times Reduction Fund, through which the federal government will require provinces to develop and report 'comparable data' on access to care, as well as to establish benchmarks for medically acceptable wait times for priority areas.

### POTENTIAL SOLUTIONS

The solution to these access-to-care barriers can be addressed through the framework of the 10-point plan established by the CMA position paper "The Taming of the Queue" (3), which addresses the broader wait time issue.

#### Set priorities through broad consultation

Cardiovascular care encompasses a broad spectrum of care delivered by various cardiovascular health professionals, as well as diagnostic testing and therapeutic interventions. Access to cardiovascular care arguably begins with access to specialist consultation by primary care practitioners. Access to risk factor modification is extremely important in disease prevention or disease modification. Access to therapeutic interventions, such as biventricular pacing, implantable defibrillator, percutaneous coronary intervention and cardiac surgery, has been shown to improve both quality and quantity of life. Access to new and emerging drugs and devices is also a growing challenge for our stretched treasuries, and fair and equitable strategies to introduce them must be developed. The public and major stakeholders need to be engaged in this discussion. Decisions made by governments based only on 'affordability', without regard for patient safety, outcomes and medical standards, cannot be regarded as legitimate in a single-payer system.

#### Address patient and public expectations through transparent communications

Patient satisfaction is improved when confidence in the integrity of a waiting list management system is established. Full transparency and public accountability for the decisions taken are needed. This requires more robust databases on risk stratification, wait lists and cardiovascular outcomes.

#### Address immediate gaps in health human resources and system capacity

Efforts must be made to plan for the future by assessing the existing capacity and the capacity for future growth in each province. Alternative models of care must be explored. Standards for access need to be set, and the ability of current resources to meet these standards and targets then needs to be assessed.

#### Improve data collection through investments in information systems

Without information systems to assess waiting times and outcomes on the wait list, intelligent and effective decision-making is severely hampered. Efforts to maintain the queue within the standard becomes more difficult, and public confidence is eroded. Investment in database and information systems infrastructure is an absolute requirement if there is to be monitored and improved access to cardiovascular care.

**TABLE 1**  
**Terms used in Access to Care Working Group commentaries**

Term	Definition
Wait time	For consultations, the time elapsed between referral by the family physician and the first consult with the specialist; for diagnostic tests, the time elapsed between decision to delivery of service; for therapeutic procedures (including surgeries), the time elapsed between the decision to treat and the procedure
Wait time indicator	Standardized measure of wait time for a given health service that is comparable across jurisdictions and provides an accurate picture of wait times for a cohort of patients
Medically acceptable wait time standard	Threshold wait time for a given health service and level of severity beyond which the best available evidence and clinical consensus indicate that patient health is likely to be adversely affected; such guidelines are intended to supplement, not replace, the physician's clinical judgment
Wait time target	A target wait time for a given health service that may be equal to or exceed the medically acceptable wait time for a given proportion of patients; a wait time target is in effect for a given period of time and represents a step along the continuum to achieving the medically acceptable wait time for all patients
Urgency	The extent to which immediate clinical action is required based on the severity of the patient's condition and considerations of expected benefit
Urgency rating score	A score based on the clinical description of an individual patient's condition to determine the urgency for care

### Develop wait time standards through clinical and public consensus

Urgency- or risk-adjusted rating scores and medically acceptable wait times can be developed, tested, verified and implemented in a relatively short period of time if the resources to do so become available. The establishment of a standard or target adjusted for risk status is a crucial first step to earning public confidence and to establishing fair access for those in the queue.

### Strengthen accountability by way of public reporting

All jurisdictions must commit to public accountability for maintenance of established standards. When standards or targets cannot be met, there needs to be clear accountability for redressing this, as well as public disclosure of both the problem and the remedy to correct the deficiencies.

### Maximize efficiencies by aligning incentives properly

Working within practice guidelines and being fully accountable for their clinical decisions, physicians should be empowered to make care delivery decisions at the individual patient level on the basis of need and consensus-determined eligibility.

### Address upstream and downstream pressures by investing in the continuum of care

Both primary and secondary prevention are important in the access to care continuum. Similarly, access to primary care for risk factor modification must be considered together with access to tertiary and quaternary level specialized care for advanced disease. All pressure points in the care continuum deserve equal consideration.

### Expand interjurisdictional care options by enhancing portability provisions

Patients who are far from comprehensive cardiac centres (including out of province) would benefit from enhancements to inter-provincial reciprocal billing agreements and a streamlining of processes that allow care to be delivered outside the usual care area.

### Commit to adoption of best practices through enhanced research and collaboration

Cardiovascular researchers have a long history of productive collaborative research relationships. For instance, the Canadian Cardiovascular Outcomes Research Team, established in 2001 (11), has contributed significantly to the body of literature in

health services and outcomes research in Canada. This group and other investigators can play an important role in the coordination of interinstitutional and interprovincial research and clinical care relationships.

## THE RESPONSE OF THE CCS

The CCS is the national professional society for cardiovascular specialists and researchers in Canada. In 2002, at the CCS Congress Public Policy Session, Senator Wilbert Keon stated that an important role of a national professional organization such as the CCS is to develop national standards for access to cardiovascular care that can be validated and adopted or adapted by the provinces. Further, he noted that it was the right time for such initiatives, given that policy-makers and the health care system were grappling with access and waiting time issues.

A professional organization such as the CCS, with its broad-based membership of cardiovascular experts, is ideally positioned to initiate a national discussion and commentary on appropriate standards for access to care for cardiovascular services and procedures. In spring 2004, the CCS Council formed an Access to Care Working Group, with a mandate to use the best science and information available to establish reasonable triage categories and safe wait times for access to common cardiovascular services and procedures through a series of commentaries.

These commentaries will summarize the current variability of standards and wait times across Canada, where this information is available. They will also summarize the currently available data, particularly focusing on the relationship between the risks of an adverse event and increasing wait times, and identify gaps in the existing data. Using best evidence and expert consensus, each commentary will take an initial position on what the medically acceptable standard for access to care ought to be for the cardiovascular service or procedure. The commentaries will also serve to call on cardiovascular researchers to fill the gaps in this body of knowledge and further validate safe wait times for given risk profiles of patients.

Definitions of access terms used in Access to Care Working Group commentaries are given in Table 1.

## CONCLUSIONS

At no other time in the history of health care delivery in Canada has access to care been such an urgent priority for the public, health care professionals, administrators and policy-makers. The timing is right for the CCS to come forward and lend its expertise

with the goal of establishing national standards for access to cardiovascular services and procedures.

The proposed series of commentaries on access to cardiovascular care will support the development of reasonable standards to assure most Canadians that they will receive the most appropriate care within a safe and appropriate time frame,

regardless of where they live. The commentaries will be about treating the right patient at the right time, and will propose solutions that incorporate the principles of transparency, accountability and broad consultation. Our aim is to facilitate the development of national standards that are worthy of the public's confidence and trust.

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