

insiders

by Christopher Simpson, associate professor of medicine at Queen's University

"Efficiencies . . . prevent complete independence of programs. But in general, programmatic governance is by its very nature more patient-centred."

Don't rob Peter to pay Paul in reducing wait times

'Success' in cutting wait times also mustn't move bottleneck upstream; shift to programmatic governance may provide simple answer

ACCESS TO CARE is the number one health-care concern of Canadians. Polls have consistently shown that a very high proportion of Canadians feel that either they or someone in their immediate family has been adversely affected by a long wait for health care.

The much-vaunted wait time strategy, launched in 2004, led to a focus on reductions in wait times for five "priority" areas: cardiac, cancer, sight restoration, joint replacements and diagnostic imaging.

Now, two years along, we are starting to hear that wait times are improved for these priority areas. However, it has been suggested we might have robbed Peter to pay Paul by merely shifting the access-to-care burden to areas with less political clout. Even within a given priority area, some suggest, we have achieved wait-time reductions only by shifting the bottleneck "upstream," a sleight of hand that has created the appearance of better access, when in fact the total wait time for the patient through the continuum may be unchanged.

The jury is still out on these claims, but the Canadian Medical Association has undertaken an online consultation of physicians to shed some light on the situation facing patients waiting for specialty care. The consultation will come to a close in a few days; however, there is still time to contribute by going to www.cma.ca/yourvoice. I'd like to suggest that you take the time to do so, and that in formulating your input, you go back to first principles in terms of what we are trying to achieve here.

Any exercise in wait list improvement has to be about the patient experience from first symptom to diagnosis, to treatment to recovery. It must focus on their perception of bottlenecks in the continuum—because it is at the bottlenecks where negative perceptions and potentially suboptimal outcomes are born.

This is where the cardiac community has set an excellent example. We all know that care is a continuum, comprising many different components, all of which have a waiting time. Somewhat uniquely, the Canadian Cardiovascular Society has, as the result of a massive effort involving more than 100 of Canada's leading cardiovascular specialists, developed a wait-time benchmark for every component of the cardiac patient experience.

This complete set of benchmarks represents a quantum leap forward not only in the way we conceptualize the wait-time experience, but in that we finally

have the tools to identify access deficits, compare jurisdictions, better understand changing pressure point dynamics and track improvements.

While few would argue with the importance of the five priority areas, we must not allow good intentions at the policy-making level to translate into an implementation strategy that

siphons resources from other areas.

The answer to this problem lies in a shift to programmatic governance—self-contained programs that shift resources within their own universe as needed and that depend minimally on other programs. Pan-continuum benchmarks then serve as the ultimate account-

ability touchstone (i.e., we are not accountable for spending "X," we are accountable for delivering quality care to our patients in "Y" time).

This seems simple but it is, in fact, quite revolutionary. True programmatic governance has to include an end to line-item ministry funding that leaves programs with little

discretionary leeway to meet these benchmarks in a dynamic environment with shifting needs and ever-changing pressure points. Efficiencies and economy-of-scale issues prevent complete independence of programs. But in general, programmatic governance is by its very nature more patient-centred.

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¹Brown JP, Josse RG, et al. 2002 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada. *CMAJ*. 2002;167(Suppl 10):S1-S34.



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It allows for more creative and ethically legitimate solutions to wait-list problems because the program will have an interest in not "hurting itself" by fixing micro-level benchmark Number 1 at the expense of micro-level benchmark Number 2, unless the overall patient experience is improved.

Also, by tagging funding to access outcomes rather than relying on artificially imposed fiscal quotas, we can achieve a truly legitimate governance model that is ultimately accountable to the individual patient—without adversely

affecting other patients in other programs.

At the end of the day, it is easy to become cynical—"It's all about money," "There is only so much to go around," etc. But in the final analysis, clarity and legitimacy can only come when we, as physicians, return to our most basic and fundamental role—that of patient advocate. The development of pan-continuum access-to-care benchmarks, coupled with honest accountability for their delivery, is certainly the way forward.

Christopher Simpson is medical director of the cardiac program at University Hospitals Kingston and an associate professor of medicine at Queen's University.

updating

by Rick Campbell



Study looks at match relationships in Big Brothers Big Sisters success

A \$1.7-million research study led by **Dr. David DeWit** (PhD), senior scientist with the Centre for Addiction and Mental Health in London, Ont., and **Dr. Ellen Lipman**, a child psychiatrist at McMaster University's Offord Centre for Child Studies in Hamilton, will examine the relative importance of match

relationship components (i.e., quality, shared activities and contact) as determinants of positive change in the health and social functioning of children enrolled in Big Brothers Big Sisters of Canada (BBBSC) adult mentoring programs. This is the first time researchers will conduct an indepth study of

involvement in BBBSC match relationships on the health of Canadian children since BBBSC's inception in 1913. The research is titled "A longitudinal analysis of the effects of adult mentoring on children's health and well-being: An examination of the Big Brothers Big Sisters Community Match Program."

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Research

The Canadian Institutes of Health Research (CIHR) has announced the EpiDREAM project will receive more than \$1.6 million over the next three years as part of its announcement of funding for 610 Ontario research projects totaling \$129 million. In addition to support from the CIHR/Rx&D Collaborative Research Program, the \$5.8-million EpiDREAM study is being funded by industry partners Glaxo-SmithKline, Sanofi-Aventis Canada, Inc., and Sanofi-Aventis Global. McMaster University researchers will team up with genetics experts from Quebec and England, as well as industry experts in genetics and epidemiology, for the EpiDREAM genetics study. It is planned that 22,000 DNA samples will be analysed from participants in 21 countries to find the genetic source for adult-onset type 2 diabetes.

Honours & awards

Dr. Joseph Pater, director of the National Cancer Institute of Canada (NCIC) Clinical Trials Group, has been awarded the R.M. Taylor medal and award. Sponsored by the Canadian Cancer Society and its research partner, the NCIC, the R.M. Taylor medal and award recognizes outstanding contributions to the cancer field. As director of the NCIC Clinical Trials Group at Queen's University for more than 25 years, Dr. Pater has presided over more than 300 cancer clinical trials that have enrolled more than 45,000 patients around the world. Dr. Pater is also a professor of medicine, oncology and community health and epidemiology at Queen's University and a physician at Kingston General Hospital. . . . **Dr. Frances Shepherd**, a researcher and physician at Toronto's Princess Margaret Hospital and a professor of medicine at the University of Toronto, is the 2006 recipient of the O. Harold Warwick Prize for her work in improving treatments for lung cancer.

Send your Updating items to Rick Campbell at rick.campbell@medicalpost.rogers.com.

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