

# THE FACTS

cupe.ca

August 2005

## Inside the Chaoulli ruling: Real solutions for shorter wait lists

### Will private health care ease wait list pressures?

No - quite the opposite. Evidence from Canada and other developed countries tells us that private payment and provision actually lengthen wait lists.

England and New Zealand, which have parallel private hospital systems, have larger waiting lists and longer waiting times in the public system than countries with a single-payer system.<sup>1</sup> Studies that have compared wait lists within countries have found similar inequalities; the more for-profit health care in a given region, the longer the waits for patients in the public system.<sup>2</sup> When public wait times dropped in Britain, it was because of increased public funding and numbers of front-line staff.<sup>3</sup>

In Sweden, which allowed the growth of private hospitals and “internal markets”, waiting lists have grown again to the levels of the early 1990s.<sup>4</sup> The number of patients on cataract waiting lists almost doubled between 1992 and 2000.<sup>5</sup> When the Stockholm Capio hospital and other for-profit hospitals failed to achieve cost savings or productivity increases, the government legislated in 2001 to prevent

municipalities from privatizing more hospitals.<sup>6</sup> More recent legislation bans any new private hospitals from treating state-insured patients, to end the practice of private patients buying their way past hospital waiting lists.<sup>7</sup>

The Australian government heavily subsidizes private health insurance, yet public wait times are similar to Canada's.<sup>8</sup> An evaluation of Australia's parallel private system by Jeremiah Hurley and his colleagues found that the government's subsidies for private insurance cost \$1.5 billion a year.<sup>9</sup> Investing this money in public hospitals would alone resolve between one-half and two-thirds of all private demand.<sup>10</sup> In 1998, the government withdrew its ban on “queue-jumping” by private patients in public hospitals, and there is evidence that the higher revenue earned from private patients is affording them preferential treatment.<sup>11</sup>

In New Zealand, market-style reforms implemented in the 1990s led to higher costs and longer waiting lists. The government instituted internal markets and invited competition between public and private hospitals. The results? Prices at private hospitals were generally higher than at public hospitals, administration costs increased 40 per cent over two years, and hospital waiting lists rose, some by as

much as 50 per cent.<sup>12</sup> The new government elected in 1999 changed course, reversing a number of commercial-oriented reforms.

Canadian experiments with private health care have similarly failed to improve waiting lists. A 1997 study by Carolyn DeCoster and her colleagues at the University of Manitoba found that patients waited longer for cataract surgery if their doctors worked in both the public and private sectors. Those patients waited up to 26 weeks, while patients whose doctors worked only in public hospitals received treatment within 10 weeks. People from high-income neighbourhoods received the faster treatment. Women waited about three weeks longer for surgery than men.<sup>13</sup>

Consumers' Association of Alberta researcher Wendy Armstrong found similar results for cataract surgery patients in Alberta. In Calgary, where all cataract surgeries were performed in private clinics, patients waited an average of 16 to 24 weeks. In Edmonton, where 80 per cent of cataract surgeries were done in public hospitals, waiting lists were five to seven weeks long.<sup>14</sup>

Why do private insurance and private delivery not solve wait time problems?

Health care providers are lured away from the public system.<sup>15</sup> The hours spent by physicians, nurses, technicians and other providers in private facilities are hours taken away from the public sector. There is already a shortage of these practitioners, and it takes many years to train more.

Since doctors earn more in the private sector<sup>16</sup>, they have an incentive to maintain

lengthy wait lists in their public practice in order to nudge patients towards their private practice.<sup>17</sup>

Private clinics and hospitals tend to “cherry pick” patients who are healthier and younger, and cater to non-emergency care.<sup>18</sup> For-profit facilities also tend to provide a lower standard of care.<sup>19</sup> Expensive cases and complications are left to the public sector, increasing demand on the public system.

As the more privileged patients – those better equipped to advocate for prompt care and adequate funding – abandon the public system, providers and governments have less incentive to resolve wait list problems.

### **What are the solutions to long wait lists?**

Better management and targeted resources are needed to tackle health care bottlenecks.

**Invest health care dollars in public delivery.** The federal government's Wait Times Reduction Fund and transfer payments for health care must be exclusively directed to non-profit service delivery. Likewise, provincial funding must be directed to public facilities, not private clinics.

**Centralize and coordinate information on wait lists.** This includes coming up with standard definitions and measurements. Currently, depending on who is keeping track, the wait list clock starts ticking at different points: when the patient is referred by their GP, gets accepted by a specialist, is booked by the hospital, or at some other marker. The

Fraser Institute has the least reliable indicator: physicians' opinions on how long they think their patients have to wait.<sup>20</sup>

**Keep lists current and valid.** Lists are often unreliable, containing patients who already had the procedure, no longer need it, or have died. Decisions about who gets what surgery often do not follow clinical practice guidelines.<sup>21</sup> Studies in Britain and other countries have shown that

between 20 and 30 per cent of patients are inappropriately placed on wait lists.<sup>22</sup> Removing people who should not be on a list reduces last minute cancellations and allows managers to better plan.

**Coordinate management of wait lists.** Most lists are kept by individual doctors, and patients are not regularly moved onto the shortest list. Progress is being made through projects like the Cardiac Care Network of Ontario, the Saskatchewan Surgical Care Network, and the Western Canada Waitlist Project.<sup>23</sup> Improving data and agreeing on benchmarks is, however, only the first step. Referring patients to shorter lists and integrating care is necessary to reduce the underlying bottlenecks.

**Centralize booking, expand case management, and improve teamwork.** Michael Rachlis recommends shared care arrangements, where family doctors consult with specialists to reduce unnecessary referrals.<sup>24</sup> Rachlis also points to the success of case managers – hospital staff who specialize in coordinating patient care, for example finding available providers, arranging patient transfers

within the region or out-of-province, and facilitating access to other services.<sup>25</sup>

**Consolidate the different steps in diagnosis and treatment.** The Sault Ste. Marie, ON, breast health centre reduced the wait time from mammogram to breast-cancer diagnosis by 83 per cent by integrating the diagnostic procedures – mammogram, ultrasound and biopsy.<sup>26</sup>

**Invest in public sector infrastructure and staffing to clear backlogs.** In some treatment areas, inadequate equipment and facilities are impeding delivery. Across the health care system, shortages of health care providers and over-taxed education systems are slowing progress. Extending the use of existing operating rooms and other infrastructure, as well as building and staffing new surgery clinics in the public sector, will help address shortfalls.

**Coordinate care to deal with underlying mismatches of capacity and demand.** Michael Rachlis argues that additional resources can help providers catch up to demand, but we need to better manage the flow of patients through the system for a lasting solution. Consolidating lists and procedures and coordinating care are necessary to make a profound dent in lists, as are democratic and transparent methods to allocate operating room time.<sup>27</sup>

**Use health care providers to their full potential, and achieve multidisciplinary collaboration.** Using nurses – RNs, practical nurses, and psychiatric nurses – as well as paramedical professionals and other practitioners to their full scope of practice will help meet demand. Faster

progress is also needed towards multidisciplinary teamwork.

**Expand services and improve coordination in continuing care.** Having community supports in place will ease pressure on emergency wards and hospital beds. A British Columbia study on home care by Marcus Hollander found that, on average, health care costs to government for home care clients were half to three quarters of costs for clients in residential care.<sup>28</sup> Inadequate funding for home care and residential long-term care has increased the burden on hospitals and exacerbated waiting list problems.

**Commit energy and resources to primary care reform.** While family practice teams and alternatives to fee-for-service have made some headway in recent years, the pace of change has been slow. Community health centres, despite their proven success, have not been expanded by most provinces. Investment in prevention of illness and management of chronic health conditions, multidisciplinary team practice, and community public health programs would improve health outcomes and reduce reliance on the acute care system.

*One in a series of six fact sheets on the Chaoulli Supreme Court ruling. Other titles in the series are: What the court did (and did not) say, Assessing the international evidence, Trade dangers of privatization, The role of drugs in rising health costs, and Taking action.*

*All can be found at [cupe.ca](http://cupe.ca).*

---

<sup>1</sup> Tuohy et al (2004).

<sup>2</sup> Duckett, S. J. (2005). Private care and public waiting. *Australian Health Review*; 29(1): 87-93; Besley, T., Hall, J., & Preston, I. (1998). Public and private health insurance in the UK. *European Economic Review*; 42(3-5): 491-497; Tuohy et al (2004). Tuohy's team also found that regions with more private insurance had longer waits in the public system – even after controlling for income, age and public spending levels.

<sup>3</sup> Lister, J. (2005) p. 149; Hughes et al (2004), p. 19.

<sup>4</sup> Saltman, R. B. (1998). Health reform in Sweden: the road beyond cost containment, in Ranade, W. (ed) (1998). *Markets in health care: A comparative analysis*. London: Longman. For a description and analysis of “internal markets”, one form of commercialization, see Lister, J. (2005), Chapter Four.

<sup>5</sup> Burgermeister, J. (2004). Sweden bans privatization of hospitals. *British Medical Journal* 328: 484. The number of cataract operations increased from 33,000 in 1992 to 57,000 in 2000, while the patients waiting for surgery increased from 16,000 to 31,500 over the same period.

- 
- <sup>6</sup> Lister, J. (2005), p. 161.
- <sup>7</sup> Burgermeister, J. (2004).
- <sup>8</sup> Tuohy et al(2004).
- <sup>9</sup> Hurley, J., Vaithianathana, R., Crossley, T. F., & Cobb-Clark, D. (2001). *Parallel private health insurance in Australia: A cautionary tale and lessons for Canada*. McMaster University Centre for Health Economics and Policy Analysis Research Working Paper 01-12.
- <sup>10</sup> Duckett, S. J. & Jackson, T. J. (2000). The new health insurance rebate: an inefficient way of assisting public hospitals. *Medical Journal of Australia* 172: 439-442.
- <sup>11</sup> Colombo, F. & Tapay, N. (2004). *Private health insurance in OECD countries: The benefits and costs for individuals and health systems*. Paris: OECD Working Papers No. 15.
- <sup>12</sup> Scott, G., McKenzie, L., & Webster, J. (2003). Maladjustments in the corporatization model: hospital reforms in New Zealand, in Preker, A. S. & Harding, A. (eds) (2003). *Innovations in health service delivery: the corporatization of public hospitals*, *Human Development Network Health Nutrition and Population Series*. Washington: World Bank; Hornblow, A. (1997, 28 June). New Zealand's health reforms: a clash of cultures. *British Medical Journal* 314: 1892
- <sup>13</sup> DeCoster, C., MacWilliam, L., & Walld, R. (2000). Waiting Times for Surgery: 1997/98 and 1998/99 Update. Winnipeg, MB: Manitoba Centre for Health Policy and Evaluation. Retrieved Aug. 15, 2005, from <http://www.umanitoba.ca/academic/centres/mchp/reports/pdfs/waits2.pdf>
- <sup>14</sup> Armstrong, W. (2000). The consumer experience with cataract surgery and private clinics in Alberta: Canada's canary in the mine shaft. Edmonton, AB: Alberta Chapter of Consumers' Association of Canada. Retrieved Aug. 25, 2005 from <http://www.albertaconsomers.org>
- <sup>15</sup> Zinn, C. (2003). Australian public hospitals face only a residual role in surgery. *British Medical Journal* 327: 12; Birrell, B., Hawthorne, L., & Rapson, V. (2003). *The outlook for surgical services in Australasia*. Centre for Population and Urban Research, Monash University.
- <sup>16</sup> Lewis, S. (2005). Physicians, it's in your court now. *Canadian Medical Association Journal* 173(3); Propper, C. & Green, K. (1999). *A Larger Role for the Private Sector in Health Care? A Review of the Arguments*. Bristol: University of Bristol Centre for Markets and Public Organizations Working Paper 99/009; Colombo, F. & Tapay, N. (2004), p. 22.
- <sup>17</sup> Canadian Health Services Research Foundation (2005).
- <sup>18</sup> Devers, K. J. (2003, April 13). Specialty hospitals: focused factories or cream skimmers? Speech and conference paper. Center for Studying Health System Change (HSC), Washington DC; American Hospital Association (2004). Impact of limited-service providers on communities and full-service hospitals. *Trendwatch* 6(2); Lister, J. (2005), p. 243; Tuohy, C. et al (2004).
-

- <sup>19</sup> Devereaux, P. J., Choi, P. T., Lacchetti, C., Weaver, B., Schunemann, H. J., Haines, T., et al. (2002a). A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal* 166(11): 1399-406; Devereaux, P. J., Schunemann, H. J., Ravindran, N., Bhandari, M., Garg, A. X., Choi, P. T., et al (2002b). Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis. *Journal of the American Medical Association* 288(19): 2449-57; McGregor, M. J., Cohen, M., McGrail, K., Broemeling, A. M., Adler, R. N., Schulzer, M., et al (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? *Canadian Medical Association Journal* 172(5): 645-9; Harrington, C. et al (2001). Carlson, M. D. A. et al (2004).
- <sup>20</sup> Canadian Health Services Research Foundation (2005).
- <sup>21</sup> Rachlis, M. (2004). *Prescription for Excellence: How Innovation is Saving Canada's Health Care System*. Toronto, ON: HarperCollins, Ch. 11 p. 3; Kennedy, J., Quan H., Gaili W. A., & Feasby, T. E. (2004). Variations in rates of appropriate and inappropriate carotid endarterectomy for stroke prevention in four provinces. *Canadian Medical Association Journal* 171(5): 455-9; Brownell, M. (2002). Tonsillectomy rates for Manitoba children: temporal and special variations. *Healthcare Management Forum* Suppl: 21-6.
- <sup>22</sup> Sanmartin, C., Shortt, S. E. D., Barer, M. L., Sheps, S., Lewis, S., & McDonald, P. W. (2000). Waiting for medical services in Canada: lots of heat but little light. *Canadian Medical Association Journal* 162: 1305-1310.
- <sup>23</sup> The Cardiac Care Network of Ontario maintains a database on cardiac surgery, angioplasty and cardiac catheterization. Data are used to measure outcomes and encourage improvements. See <http://www.ccn.on.ca>. The Western Canada Wait list Project is developing urgency rating scales (standardized measures to assess which patients need care most) for cataract surgery, children's mental health services, general surgery, hip and knee replacement, and MRI scanning. See <http://www.wcwl.ca>. The Saskatchewan Surgical Care Network is developing a surgical registry and performance standards and monitoring hospital capacity. See <http://www.sasksurgery.ca>.
- <sup>24</sup> Rachlis, M. (2004) Ch. 11, p. 8.
- <sup>25</sup> Ibid, pp. 11-12.
- <sup>26</sup> Ibid, p. 9.
- <sup>27</sup> Ibid, Ch. 11.
- <sup>28</sup> Hollander, M. J. (2001). Comparative cost analysis of home care and residential care services. Substudy 1 of the National evaluation of the cost effectiveness of home care. A report prepared for the Health Transition Fund, Health Canada. Retrieved Aug. 25, 2005, from [www.homecarestudy.com/reports/full-text/substudy-01-final\\_report.pdf](http://www.homecarestudy.com/reports/full-text/substudy-01-final_report.pdf)