The College of Family Physicians of Canada

Le Collège des médecins de famille du Canada

WHEN THE CLOCK STARTS TICKING

Wait Times in Primary Care

Discussion Paper

October 2006

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The College of Family Physicians of Canada (CFPC) strives to improve the health of Canadians by:

- Ensuring the highest standards of training, certification, and maintenance of proficiency for family physicians;
- Educating and informing the public about healthful living;
- Supporting research and disseminating knowledge; and
- Championing the rights of every Canadian to high-quality health care.

Representing 17,800 family doctors across the country, the CFPC is the collective voice of family medicine in Canada. Its members are committed to the Four Principles of Family Medicine:

- The patient-doctor relationship is central to all we do.
- Family physicians must be skilled clinicians.
- Family physicians should be a resource to a patient population.
- Family medicine is a community-based discipline.

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When the Clock Starts Ticking

Wait Times in Primary Care

- Discussion Paper -

Introduction

For many years The College of Family Physicians of Canada (CFPC) has advocated on behalf of Canadians for appropriate and timely access to all aspects of health care through their family physicians. The College's positions have taken into account the needs of Canadians as patients waiting in line to receive services throughout the continuum of their health care. This includes not just the wait time between the first visit with a consulting specialist and the patient's definitive procedure, surgery or treatment – but also the time between the patient's first visit with his/her family physician and when required, a subsequent visit with a consultant. It also includes the time it takes for a Canadian who does not have a family physician to find one.

While most research on wait times has addressed the time between the visit with the consulting specialist and the completion of a procedure or treatment, very little has addressed the time from the patient's first interaction with the primary care system, i.e. the first visit with a family physician for a particular problem through to more specialized care with a consulting specialist if required. This is a critical time period when the patient and family physician together wait for more specialized advice, investigation or treatment. It is a time interval that must be included in the determination of acceptable and safe wait times for patients

With few exceptions, evidence-based research on wait times between visits with family physicians to consultation with other medical specialists is seriously lacking. While reports such as those from the Wait Time Alliance and Canadian Psychiatric Association offer hope, as do a few other international experiences, much more work remains to be done if we are to understand the issues that concern Canadians and wait times in primary care.

In examining this issue, it is apparent that measuring wait times in the primary care environment is exceedingly complex and requires an appreciation of many different interactions between the primary care system in which family physicians serve their patients and more highly specialized care in other parts of the health system. For most patients, wait times for more highly specialized services occur while they are under the care of their family physician or as an important part of shared care between their family physician and other consulting specialists.

Challenges in Primary Care Wait Time Measurement

When *starting to build wait time benchmarks in primary care,* there are a number of challenges that contribute to the complexity of this task. These include:

1) Number of Canadians without a family physician to help them access health care, the result of physician shortages.

2) Lack of evidence-based studies for wait times in primary care.

3) Focus to date on data and information that are mainly related to the federal government's five defined areas for wait time management.

4) Consideration given to mainly highly specialized services for wait time measurement.

5) Difficulty in understanding the most appropriate wait times for undifferentiated conditions seen in primary care.

6) Need to develop clinical guidelines to define the diagnostic criteria that must be met for a patient in primary care to be registered on a wait list that guarantees treatment within a defined period of time.

7) Concerns of health care professionals, including family physicians, regarding the responsibility to meet wait time benchmarks, with the potential to increase tension that already exists in the health system, particularly in the face of physician shortages.

8) Potential to increase other political and financial tensions that will face governments and health authorities as accountability for health system resources are defined to try to meet much longer lists of primary care wait time benchmarks.

Away from Home – International Experiences

Internationally, there is increasing experience managing wait times in primary care. The conclusion that can be drawn from reviewing the literature however is that there are many different ways of approaching this challenge and the need remains for more research to determine how best to measure and manage wait times in primary care.

In attempting to reduce wait times for those accessing health care in England, the National Health Service (NHS) focused on ensuring that 99% of its citizens have access to a general practitioner.[1] In fact, in 2004, the standard for wait time benchmarks set by the NHS was that patients should be able to see a primary health care professional within 24 hours and a general practitioner (family physician) within 48 hours.[2]

Canada's primary care system does not fare well when comparing patient access to **same-day appointments** between five similar countries. (*See **Figure I***.) In 2004 Canada was identified as the country with the lowest percentage of citizens who could access a physician with a same-day appointment (27%), compared to the United States (33%), the United Kingdom (41%), Australia (54%) or New Zealand (60%). Likewise, barriers to accessing primary care resulted in the highest percentage of patients (25%) **waiting 6 days or more** to visit a physician in Canada when compared to the same five countries: the United States (19%), the United Kingdom (13%), Australia (7%) and New Zealand (2%). When the Commonwealth Fund extended this study in 2005 to include Germany and examined primary care wait times of **four weeks or more** to see a "specialist", Canada came in second lowest with 57% of its citizens waiting at least this long to access specialty care, compared to the United States at 60%. By comparison, Australia was better at 46%, the United Kingdom at 40%, Germany at 23% and New Zealand at 22%.

Considering that Canada ranks only 26th out of 30 OECD countries in its supply of physicians to serve the population,[3] and that a greater supply of primary care physicians is strongly related to improved health outcomes,[4] there is good reason to believe that problems in access to care (as identified above) and the quality of care could be significantly improved by finding solutions to increase the number of family physicians in Canada. These are challenges that federal, provincial and territorial governments must continue to address in consultation with appropriate stakeholders, including the CFPC.

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[1] Presentation by Dr. David Colin-Thomé: *Global Perspectives on Primary Care - Accelerating Primary Care Conference*, February 15, 2006, Edmonton, Alberta, Canada.

[2] Peter Bower, Martin Rowland, John Campbell, Nicola Mead, *Setting standards based on patients' views on access and continuity: secondary analysis of data from the general practice assessment survey*, British Medical Journal, 2003 Feb; 326; 258.

[3] Organization for Economic Cooperation and Development [OECD] (2004), *OECD Health Data 2004: A Comparative Analysis of 30 Countries*, 3rd ed. CD-ROM. Paris.

[4] Starfield, Barbara, Leiyu Shi, Atul Grover, James Macinko, *The Effects of Specialist Supply on Populations' Health: Assessing the Evidence*, Health Affairs, Web exclusive, March 15, 2005.

Figure I: Percent (%) of Population Accessing a Physician within Defined Wait Times In Six Developed Countries

	Australia	Canada	New Zealand	United Kingdom	United States	Germany
Same Day Appointment to See Physician	54	27	60	41	33	
Wait of 6 Days or More to See Physician	7	25	2	13	19	
Wait of More Than 4 Weeks to See a Specialist	46	57	22	40	60	23

Sources of Information:

1) Commonwealth Fund 2004, *Primary Care and Health System Performance: Adults' Experiences in Five Countries* (access to physician when sick or need medical attention on same day or after wait of six days or more)
2) Commonwealth Fund 2005, *2005 International Health Policy Survey* (access to specialist after more than four weeks)

Sweden and Norway have each taken unique approaches to managing primary care wait times. Their experiences were presented at an Ottawa conference in March 2006: *Taming of the Queue III*. Sweden guarantees same-day access to a primary care centre (not necessarily to a physician) and access to a physician within seven days. Sweden's wait time guarantee also includes a 90-day maximum to see a specialist with another 90-day maximum following the specialist visit for starting specialty treatment. *(See **Figure II**.)* This linear approach to establishing wait time guarantees could stimulate further thinking about how Canadians address the challenges of primary care wait times in this country.

Figure II: Sweden's Wait Time Guarantee

0	7	90	90
Guaranteed access to local primary care centre same day	Access to see a physician within seven days	Maximum ninety days to see a specialist	Treatment started maximum ninety days from seeing a specialist

What appears to have worked best to date in Norway has been the introduction of patient choice between providers, that is, giving patients the tools to decide where they could seek treatment and allowing them to choose where to go and whom to see. The regionalization of health care delivery to allocate resources more appropriately and the use of private care providers in the publicly funded system were two other solutions presented as strategies that helped the Norwegian health system achieve improved wait times. *(See **Figure III**.)*

Figure III: Norwegian Experience

Lesson Learned	Effect Achieved**
1. Mandate patients' rights to treatment by law – set maximum wait times by law	○
2. Increase spending (within own country) – use more money / increase capacity	○
3. Buy services from abroad – allocate additional funds for treatment abroad	○
4. Introduce real patient choice between providers – allow patients to choose where to get treatment and give them the tools to make these choices	●
5. Change financing system and incentives – move from fixed budgets to fee-for-service delivery for hospitals	●
6. Change governance model – regionalization with ability to determine where health care needs should be met	●
7. Introduce private providers – allow private providers to operate within publicly financed hospital system	●

(****** - darkened circle indicates better achievement)

Source of Information for ***Figures II and III***:

Adapted from presentation by Ms. Marit Vaagen: *Increasing Certainty – Learning from International Experience with Care Guarantees and Related Wait Time Policies*, Taming of the Queue III Conference, March 31, 2006, Ottawa, Ontario, Canada.

Close to Home – Canadian Experiences

The literature on Canadian experiences with wait times in primary care reveals challenges that are similar to those in the international literature. Inconsistencies in findings and a range of experiences allow at least one conclusion to be drawn: the need for more evidence-based research.

Access to Family Physicians

In 2003 Statistics Canada reported that of 3.6 million Canadians without a family physician, 1.2 million (5%) could not find one.[5] Three Decima polls over three years between 2003 and 2005 reported an even higher number of Canadians without a family physician – 15% or approximately 5 million Canadians.[6] While the Decima polls did not ask how many had searched for a family physician, it is known that many Canadians who would like to have a family physician do not even bother looking because they are already aware that they cannot find one. Residents in most communities quickly learn whether any family physicians have "open" practices; i.e. practices willing to take new patients. In many instances, those without a family physician access primary care through a community walk-in clinic or hospital emergency department, thus assuming the mantle of "orphan patients". This is the unfortunate reality of the growing family physician shortage that so many have identified over the past five to ten years.

In the 2003 Statistics Canada survey, 86% of Canadians reported that they had access to a regular family physician. Yet even patients with a family physician encountered problems accessing primary care. In a further analysis by Sanmartin and Ross, it was reported that 15% of Canadians with a family physician reported difficulties accessing "routine" care and 23% reported problems accessing "immediate" care for minor health problems.[7] Not surprisingly, those Canadians without a regular family physician were more than twice as likely to report difficulties accessing "routine" care compared to those with a regular physician. Of interest, Sanmartin and Ross also reported however, that respondents with a regular family physician were just as likely to experience difficulties in accessing "immediate" care as those without a regular physician. Similar findings have been borne out by Love et al (1999), Periera et al (2003), and Mathews et al (2003). Physician and/or service availability were cited as top reasons for difficulties in accessing "routine" or "immediate" care.

These findings demonstrate that even Canadians with a family physician may experience difficulties receiving timely care. An important reason for this is that the schedules of busy family physicians are filled and, given physician shortages and increasing patient loads, the limited number of family physicians who are available must use triage approaches and simply cannot see all patients in as timely a manner as they and their patients might hope.

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[5] Statistics Canada, Canadian Community Health Survey, Health Services Access Survey, 2003
[6] Decima Polls, 2003-2005, commissioned by The College of Family Physicians of Canada, 2003-2005.
[7] Claudia Sanmartin and Nancy Ross, *Experiencing Difficulties Accessing First-Contact Health Services in Canada*, Healthcare Policy, Vol. 1 No. 2, 2006.

The CFPC contends that every Canadian should have the opportunity to have a family physician.[8] With their own family physician, Canadians are able to access and navigate the health care system better. A Decima poll conducted in 2004 revealed that 88% of Canadians believed having a family physician allowed them to feel much more confident in their ability to receive appropriate and timely care.[9] Those with a family physician typically view access and the health care system itself much more positively than those without a family physician.[10]

The National Physician Survey 2004 (NPS 2004) found that 60% of practising family physicians were seeing few to no new patients.[11] These physicians had closed or restricted their practices due to either excessive patient volumes (demand-related) or changes in practice patterns (supply-related). A more recent 2006 study by The College of Physicians and Surgeons of Ontario found that only 11.4% of Ontario family physicians reported they were accepting new patients, down from 38.4% five years ago. The study went on to say that when taking into account the number of family physicians practicing comprehensive family medicine, the percentage who reported they were accepting new patients decreased to 3.6%.[12]

Advanced or *open access*, which facilitates same day appointments, has been introduced to primary care practices internationally as well as in Canada. A prominent advocate for advanced access as a way to improve primary care wait times is The Health Quality Council of Saskatchewan under the leadership of Dr. Ben Chan.[13] The Council advocates same-day appointments in addition to pre-booked appointments for primary care physicians. While not every appointment will or should be the same day, patients presenting with acute, semi-urgent or non-urgent symptoms, may benefit from advanced access scheduling by their family physician. *(See **Appendix** for more information on **Advanced or Open Access Scheduling**.)*

Access to More Highly Specialized Services

There is evidence to suggest that Canadians experience much greater difficulties with timely access to more highly specialized services than to primary care services. The results of a Decima Research survey released in August 2006 revealed that more than one in three Canadian households had tried and failed to get timely access to at least one

[8] *Family Medicine in Canada: Vision for the Future*, The College of Family Physicians of Canada, November 2004.
[9] Decima Poll, commissioned by The College of Family Physicians of Canada, September 2004.
[10] 6*th* *Annual National Report Card on Health Care*, Canadian Medical Association, August 2006.
[11] National Physician Survey 2004 (NPS 2004), census survey of all physicians in Canada, collaboration between The College of Family Physicians of Canada, The Royal College of Physicians and Surgeons of Canada and the Canadian Medical Association, supported by the Canadian Institute for Health Information and Health Canada.
[12] The College of Physicians and Surgeons of Ontario, News Release, June 22, 2006.
[13] *ABCs of Advanced Access*, Health Quality Council Review, Summer 2004, Health Quality Council of Saskatchewan.

health service within the previous three months.[14] Of the 3,000 Canadians surveyed, Decima reported the proportion that had to wait an unreasonable time was:

- 45% for an appointment with a "specialist"
- 30% for tests to confirm a diagnosis
- 20% for an appointment with a family physician

In 2005, 41% of Canadians reported that they had to wait one to three months to see a specialist[15] and another 12% longer than three months. Likewise, 32% of Canadians in 2005 had to wait one to three months for a diagnostic test[16] and another 11% waited longer than three months. While it is acknowledged that the benchmarks for primary care wait times to see a "specialist" or to have a "diagnostic test" are unknown at this time, concerns may at least be raised about the more than 10% of Canadians who had to wait longer than three months for either event in 2003 and 2005. *(See **Figure IV**.)*

Figure IV: Percent Who Received Defined Care within a Specified Period of Time

Wait time …	Less than 1 Month	1 to 3 Months	Longer than 3 Months
Specialist Visits			
• 2003	48	41	11
• 2005	47	41	12
Diagnostic Tests			
• 2003	58	31	12
• 2005	57	32	11

Source of Information:
Statistics Canada, Health Statistics Division, *Access to Health Care Services in Canada*, January to June 2005, released in January 2006, Catalogue no. 82-575-XIE (self-reported patient surveys).

The NPS 2004 confirmed that patients not only encounter barriers in accessing primary care, they also experience significant obstacles when their family physicians try to refer them to more highly specialized care. For example, 23% of consultants indicated they could not see a patient with an urgent medical problem within one week of referral from

[14] Decima Research Inc, *How Many Wait Too Long For Health Care?* August 23, 2006.
[15] "Specialist" visit wait times were defined as the time between when individuals and their physician decided that they should see a specialist and the day of the visit. These were visits to obtain a diagnosis for a new illness or condition and did not include ongoing care.
[16] "Diagnostic" test wait times were defined as the time between when individuals and their physician decided to go ahead with a test and the day of the test. A diagnostic tests was an MRI, CT scan or angiography requested by a physician to determine or confirm a diagnosis (not x-rays and blood tests).

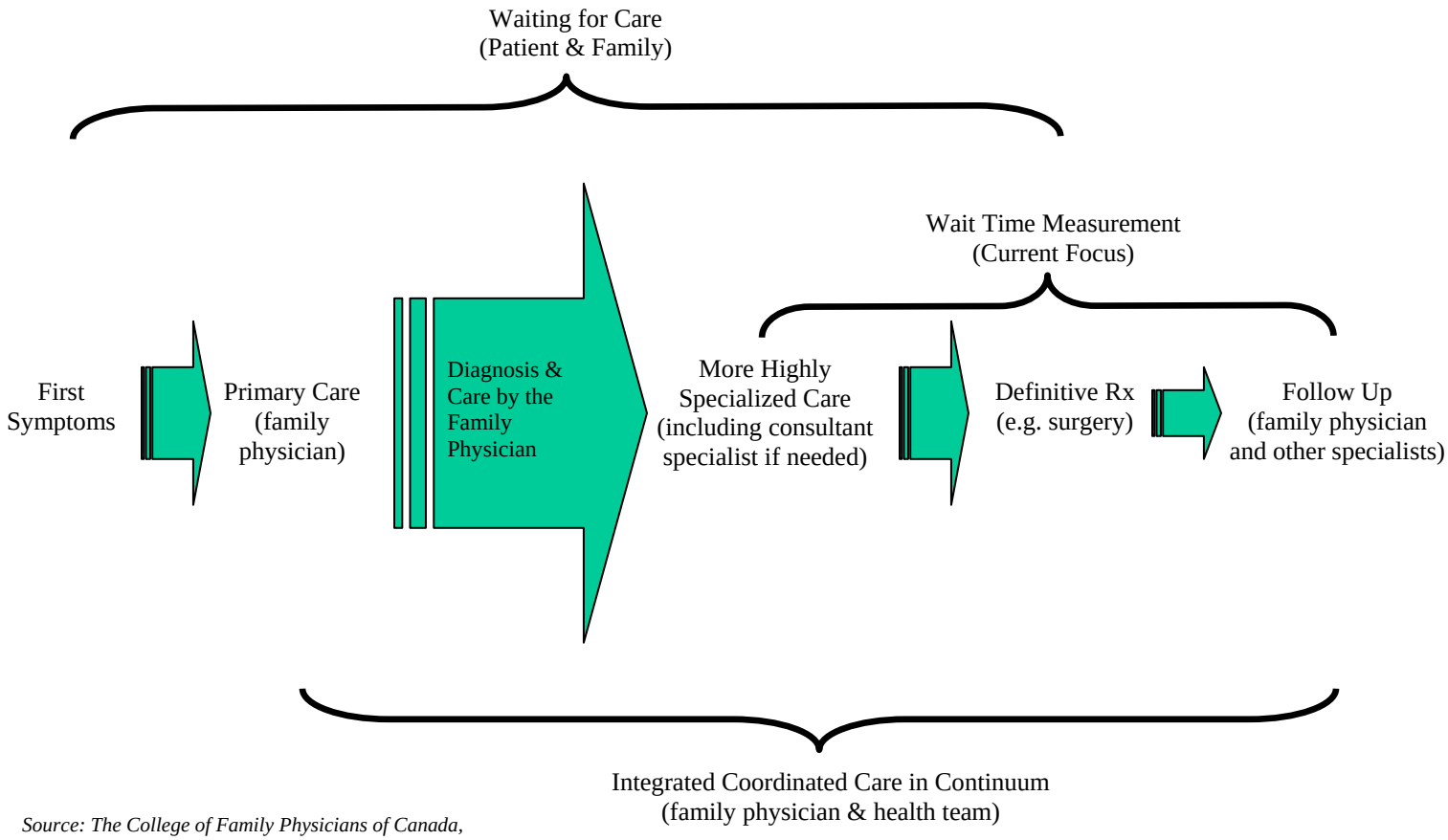
the patient's family physician and 27% indicated they could not see a patient with a non-urgent medical problem in less than three months from referral. In particular, access to psychiatrists was rated fair to poor by 66% of family physicians who responded to the NPS 2004 and access to orthopaedic surgeons fair to poor by 48% of family physicians. Of all responding physicians in the NPS 2004 (family physicians as well as other specialists), 54% rated access to advanced diagnostic services as fair to poor and 41% rated access to hospital care for elective procedures as fair to poor.[17] These findings have serious implications for wait time management and the establishment of benchmarks and guarantees. They also suggest a need for further direction in deciding where wait time management should focus in the continuum of care from primary to more highly specialized care.

[17] NPS 2004 (as per footnote #11).

When the Clock Starts Ticking:
Challenges in Measuring Wait Times in Primary Care

The Canadian Medical Association's Wait Time Alliance (WTA) Report released in 2005 stated that wait times should be measured from the onset of symptoms to treatment and rehabilitation. Using reference to the CFPC's working document on wait times, the WTA Report concluded that for most patients, wait time measurement should include the whole wait time, not just part of it, from the beginning to the end of the patient's interaction with the health care system. *(See **Figure V**.)* In the CFPC's 2004 *Family Medicine in Canada: Vision for the Future*, the CFPC stated that: "Wait times should be defined from when patients experience a problem and attempt to seek care through being seen by family physicians, through specialist consultation and specialty interventions, until definitive care is carried out."[18] The WTA Report concurred in 2005 and noted that: "the clock starts ticking long before a patient ends up in another specialist's office."[19]

Figure V: Focusing on Wait Times



Source: The College of Family Physicians of Canada, September 2006

[18] Family Medicine in Canada: Vision for the Future, p. 35
[19] *It's about time!*, Final Report by the Wait Time Alliance, August 2005, p. 68.

For too many Canadians, the clock starts ticking without the advantage of a family physician to advocate for and to help them access the care they require. Not only do they have more difficulty in accessing care but their experiences with the health system and their perceived quality of health care is less.[20] For many Canadians, wait times in primary care are all about finding a family physician.

For the WTA, the patient's wait time for specialty care begins when he or she receives a differential diagnosis from the family physician or general practitioner: that is, when "wants" get translated into "needs" and it is decided that the patient requires diagnostic testing or clinical intervention.

… quote from *It's about time!* WTA Report 2005

Examining primary care wait times more closely reveals unique challenges in measuring the time from beginning to end. What points should the health care system define as the beginning and the end of a patient's wait time? If the *entire* patient experience is taken into account, then wait times should start with the onset of the patient's symptoms and end when these symptoms are relieved. In practical terms, the end is easier to define, e.g. when definitive care, such as surgery or another procedure has been carried out. Some have suggested that the starting point for wait times in primary care should be defined as the point at which the family physician arrives at a differential diagnosis. This approach respects the range of both undifferentiated and differentiated medical problems seen in primary care. For example, a patient experiencing fatigue (an undifferentiated problem) may simply be tired from over-activity - or the patient's fatigue may be the beginning of a serious illness, e.g. a bleeding peptic ulcer (a more differentiated problem). Most would agree that the wait time in this example is almost impossible to measure until at a minimum, the differential diagnosis of a bleeding peptic ulcer is defined by the family physician and used as the starting point. Because so many patients access primary care in undifferentiated states with no diagnostic label attached, defining wait times in primary care presents a greater challenge than measuring wait times after patients are referred to more highly specialized care. For those patients without a family physician, this challenge is much greater.

Further to the above, an argument could be made that the wait time until definitive treatment for the patient with a bleeding peptic ulcer should include consideration for the time the patient first presented with fatigue.

Regardless of how the wait time starting point is defined, the level of urgency is a crosscutting issue that adds to the complexity of wait time management in primary care. Levels of urgency apply whether it is to see a family physician or to see a consulting specialist. However, the interpretation of how urgent a problem is differs between patients and family physicians and between family physicians and consulting specialists. While waiting longer than 24 hours to see a physician is often inappropriate for patients in an emergency or even in some urgent situations, waiting four to six weeks may be

[20] 6*th* *Annual National Report Card on Health Care*, Canadian Medical Association, August 2006.

acceptable for the management of a stable chronic disease such as diabetes mellitus. Yet for the patient with diabetes and a worsening complication such as a deepening diabetic ulcer, waiting four to six weeks for further advice may be far too long after referral from the family physician to the appropriate consulting specialist.

Examining Wait Times in Primary Care More Closely

While the five medical areas chosen by governments and the Wait Time Alliance are all very important, (cancer care, cardiac care, cataracts, hip-knee replacements and MRIs/CTs), there are significant concerns that the focus on just these five is too restricted and will lead to resources being siphoned from areas of care not included to support those named. For example, in September 2006, the Ontario government announced another $108 million in funding for wait times, half of which is to go towards the same five key areas while the other half to support more rehabilitation programs, Ontario's Wait Times Information System and local communities trying to reduce wait times. These are welcome announcements but still leave considerable uncertainty about a focus on wait time management in primary care.

A few case scenarios may help to explain the concerns noted above.

> For family physicians in many communities across Canada, getting a timely appointment with an ophthalmologist for a patient requiring cataract surgery might not take as long as it does to get a timely appointment for a patient with a complicated red eye that is not responding to treatment. With more government incentives now given to funding cataract procedures, obtaining the cataract extraction within a timely period may not be difficult in some communities. This “ballooning effect” is a result of extra resources dedicated to one area of care with the consequence that another area suffers and is, of course, exacerbated when there is a shortage of physicians. This example also illustrates the wait time challenge inherent in measuring primary care wait times for less differentiated diagnostic conditions. The appointment for the more urgent red eye patient may not only be more difficult to obtain, but measuring the wait time is a greater challenge that depends on a definite diagnosis first being made.
>
> In some communities, it might be easier to arrange a timely appointment with an orthopaedic surgeon for a patient with osteoarthritis requiring a knee replacement than to arrange a timely appointment for a patient with ongoing knee pain for which an arthroscopy should be considered to make a diagnosis. In the former instance, the patient has usually been followed for some time and the knee replacement is now considered the definitive treatment to help with an increasingly disabling condition. As the funding incentives are on the side of the patient requiring the knee replacement, the appointment for the patient with knee pain might be harder to arrange, even if more urgent. And with the uncertainty of diagnosis, measuring the wait time for this patient is also more difficult to accomplish.

The primary care wait times for these scenarios may differ in different communities in Canada. While some communities may have excellent resources for access from primary to more highly specialized care for certain illnesses or diseases, others may not be as well resourced and therefore not as able to respond. Wait times relevant to primary care can

therefore be influenced not only by the uncertainty of diagnosis and level of urgency but also by the availability of more highly specialized resources in a given community. Another overlooked aspect of all these scenarios is the ongoing support required by the patient whose condition is being monitored and whose medical complications are being managed by the family physician while awaiting the next phase of treatment or care.

In summary, waiting for care occurs throughout the patient's continuum of care and the **starting point** for wait time measurement should consider the patient's whole experience in the health care system. Is the starting point:

a) When the patient is symptomatic and trying to find a family physician?
b) When the patient first sees the family physician?
c) When the family physician schedules investigations and/or procedures to help reach a diagnosis, (e.g. x-rays, ultrasounds or more specialized tests such as MRIs or CTs)?
d) When the symptoms, signs or investigations allow the family physician to develop a differential diagnosis?
e) When a definitive diagnosis is made by the family physician, resulting in the initiation of medical management without referral to a consulting specialist?
   OR
   When a definitive diagnosis is made by the family physician, resulting in a decision to refer to a consulting specialist?
f) When the patient is scheduled to see the consulting specialist?
g) When the patient sees the consulting specialist?
h) When the consulting specialist schedules a specialized procedure or intervention to determine a diagnosis and/or further treatment?
i) When the consulting specialist starts the patient's medical or surgical treatment?

In addition, **levels of urgency** impact every patient encounter and the determination of safe and appropriate wait times. Levels of urgency can be defined as:[21]

a) **Emergent** – a situation that is an immediate danger to life, limb or organ
b) **Urgent** – a situation that is unstable and has the potential to deteriorate quickly and result in an emergency admission
c) **Semi-urgent** – a situation involving some pain, dysfunction and disability but stable and unlikely to deteriorate quickly to the point of becoming an emergency
d) **Elective** (also called non-urgent or scheduled care and can apply to preventive care as well as chronic disease management) – a situation that while potentially involving pain, dysfunction or disability, is being routinely managed, not expected to deteriorate quickly, and not an immediate threat to life, limb or organ

[21] Adapted from definitions in *It's about time!,* Wait Time Alliance, August 2005, p. 3.

Starting to Build Wait Time Benchmarks in Primary Care

Although developing wait time benchmarks in primary care is relatively unexplored territory in Canada, some recently released reports may help to give direction to the building blocks needed for this work. These reports include:

a) Wait Times Alliance (WTA) Report – August 2005
b) Canadian Psychiatric Association (CPA) Report – March 2006
c) Fraser Institute Report – October 2005

In ***Figure VI***, primary care wait time benchmarks have been identified from the WTA and CPA Reports. An examination of this information suggest the potential to further develop and reach consensus related to wait times for a much broader range of conditions seen by family physicians in primary care. Using such information, it should be possible to develop wait time benchmarks in primary care, cross-checked with levels of urgency.

While evidence will be important in establishing wait time benchmarks, it is also important to remember a statement from the WTA Report:[22]

The setting of benchmarks must be evidence-based but not evidence-bound.

In the context of primary care wait times, this statement is a reminder that the absence of concrete evidence for wait time benchmarks in primary care should not be a barrier to defining reasonable benchmarks using the experience and expertise of health care professionals and leaders from credible organizations including the CFPC – while acknowledging the need to maintain an openness to reassess these benchmarks if better or more reliable information becomes available.

The establishment of wait time benchmarks in primary care should be pursued to improve access for all Canadians in the health care continuum from primary to more highly specialized care. The application of wait time benchmarks to an individual patient should be based on clinical guidelines that define the diagnostic criteria to be met for a patient to enter a wait list. The use of these guidelines should be flexible, allowing opportunity for the best evidence and expert opinion in each patient's unique situation. Wait time benchmarking should not exclude the use of clinical judgment and should respect the valued relationship that exists between a patient and his/her own family physician.

[22] *It's about time!*, Final Report by the Wait Time Alliance, August 2005, p. 2.

Figure VI: WTA and CPA Wait Time Benchmarks for Defined Services By Levels of Urgency

	Emergent	Urgent	Semi-urgent	Non-urgent or Scheduled
Radiology (CT scans & MRIs)	Immediate to 24 h	Within 7 days		Within 30 days
Nuclear Medicine • Bone scans • PET scans • Cardiac imaging • Bone density	 Immediate to 24 h Immediate to 24 h Immediate to 24 h	 Within 7 days Within 7 days Within 3 days		 Within 30 days Within 30 days Within 14 days Within 30 days
Joint Replacement (hip and knee replacement surgery)	Immediate to 24 h			Priority 1: within 30 days Priority 2: within 90 days Priority 3: consult'n within 3 months
Cancer Care (radiation therapy)	Immediate to 24 h	Individual need		Consult'n within 10 working days
Sight Restoration (cataract surgery)		Proportional to degree of severity		
Cardiovascular Services • Initial referral • Nuclear imaging • Heart failure services • Electrophysiology – Pacemaker – Testing/ablation • Rehabilitation	 Immediate to 24 h 1 working day Immediate to 24 h Immediate to 3 d Immediate	 7 days 3 working days 14 days 14 days 14 days 7 days	 4 weeks 4 weeks 30 days	 6 weeks 2 weeks 6 weeks 6 weeks 3 months 30 days
Serious Psychiatric Illness • First episode psychosis • Mania • P-p severe mood disorder or psychosis • Major depression	 Within 24 h Within 24 h Within 24 h Within 24 h	 Within 1 week Within 1 week Within 1 week Within 2 weeks		 Within 2 weeks Within 4 weeks Within 4 weeks

Sources of Information (includes only wait times that would usually be initiated by referral from the patient's family physician):

1) Adapted from Wait Times Alliance Report: *It's About Time!* (August 2005).
2) Adapted from Canadian Psychiatric Association Report: *Wait Time Benchmarks for Patients with Serious Psychiatric Illnesses* (March 2006)
   CPA report defines levels of urgency as - Emergent – deemed appropriate after triage
   - Urgent – within 24 hours
   - Scheduled – within 1 week

In ***Figure VII***, data from The Fraser Institute have been used to identify wait times from referral to consultation and to treatment for some of the same clinical areas of interest to Canadian governments and the WTA. These data support concerns about overall increases in primary care wait times in Canada from 1993 to 2005, as well as special concerns about joint replacements and sight restoration. The data also suggest that wait times have improved in some areas, e.g. elective cardiovascular surgery. No data on diagnostic testing or serious psychiatric illness are available from this report.

Figure VII: Median Wait Times (Weeks) Between "GP" Referral And Specialty Appointment or Treatment for Defined Services

Time Period …	To Appointment 1993	To Appointment 2005	To Treatment 1993	To Treatment 2005
Overall	3.7	8.3	9.3	17.7
Radiology or Nuclear Medicine (No data)				
Joint Replacement • Orthopaedic surgery	8.1	14.7	19.5	40
Cancer Care • Radiation oncology	1.9	1.6	5.3	5.7
Sight Restoration • Ophthalmology	4.5	14.3	14.6	27.4
Cardiovascular Services • Cardiovascular surgery • Cardiovascular surgery (elective)	3.4	3.1	13.2	8.3
Serious Psychiatric Illness (No data)				

Source of information:

Adapted from The Fraser Institute report, *Waiting Your Turn* (October 2005)

- Data used from Canadian surveys and provincial sources - 1993 to 2005
- Table only identifies services similar to those used by WTA and CPA Reports

Achieving Wait Time Benchmarks in Primary Care

Over the past few years, many strategies have been undertaken to try to improve patient access and to address wait time challenges in primary and more highly specialized care. Some of these have been discussed at great length in policy papers from governments as well as health care and medical organizations, including the CFPC. The recommendations in these reports should be implemented as soon as possible. For example, to address family physician shortages in Canada, it has been recommended that there should be at least 2500 medical school entry positions in Canada by 2008 with a minimum of 45% of all first year post-graduate positions allocated to family medicine.[23]

Improving wait times in primary care will require action. The College of Family Physicians of Canada recommends that:

a) Benchmarks in primary care be established to define acceptable wait times by levels of urgency for patients:
    i) To find a family physician;
    ii) To be seen by their own family physician; and,
    iii) To be seen by consulting specialists.

b) Appropriate wait time benchmarks be developed and established for patients waiting for other services within the five clinical areas already identified by governments in Canada, as well as other areas in which patients wait for care beyond these five.

c) Governments support the funding and resources needed in the Canadian health care system to develop and establish primary care wait time benchmarks.

d) The health system supports timely access to comprehensive and seamless care in the wait time continuum from primary to more highly specialized care.

e) Governments support wait time benchmarks recommended in the WTA and CPA Reports that identify the time patients wait for care from referral by their family physician to more highly specialized services and definitive treatment or intervention.

f) A pan-Canadian infrastructure be established for the analysis and planning of appropriate health human resources to meet the needs of Canadians for timely access to care.

g) Family physician as well as other health human resource shortages in Canada be remedied as soon as possible.

h) Interdisciplinary models of care that value the unique roles and responsibilities of each care provider be developed, including preservation of the relationship between patients and their own family physician for timely access to all aspects of care.

[23] *Family Medicine in Canada: Vision for the Future*, The College of Family Physicians of Canada, November 2004.

i) Medical students and residents in all specialties, including family medicine, be educated and trained using role models and teaching about the importance of advocating for patients to access all levels of care within benchmarked wait times.

j) New or changing ways to schedule patients be explored for access to primary care and family physician services, e.g. advanced or open access scheduling in family practice *(see **Appendix**).*

k) A primary care wait time alliance led by the CFPC and CMA be established to study, develop and recommend primary care wait time benchmarks that ensure the best possible access to a full spectrum of health care for all Canadians.

Concluding Remarks

This document highlights the need to address wait times in primary care while considering the challenges associated with achieving this. Moving toward the establishment of primary care wait time benchmarks will require recognition of the complexity of care that impacts wait times in primary as well as more highly specialized care. The central role of the family physician-patient relationship should be preserved and strengthened with all strategies that are used to address wait time benchmarks.

Wait time benchmarking should not exclude the use of clinical judgment and should respect the valued relationship that exists between a patient and his/her own family physician.

The College of Family Physicians of Canada believes that every Canadian should have the opportunity to have his or her own family physician. To achieve appropriate wait times in primary care, there are health human resources as well as educational and training challenges that must be met. Ensuring adequate family physician human resources in and of itself will contribute to the achievement of primary care wait time benchmarks for those Canadians seeking a family physician or whose access to their own family physician is hampered by shortages experienced in many communities.

Wait times in primary care are complex and require the consideration of a variety of influencing factors, including the patient's expectations, the resources that are in the health system (including human, equipment and facilities), and levels of urgency. Measuring primary care wait times and agreeing to primary care wait time benchmarks will require consensus from a broad range of stakeholders, including patients and providers, especially family physicians who are challenged everyday to access health care services on behalf of their patients. The College of Family Physicians of Canada believes that wait time benchmarks should be established to meet universal expectations for access to both primary and more highly specialized care. Governments and other key stakeholders must respect these benchmarks and be held accountable so that Canadians can receive the most appropriate care in the most timely way.

Appendix:

Advanced or Open Access Scheduling – A Special Time Management Solution

Given the challenges that have been described for wait times within primary care, a solution that is taking on increasing importance for patients first seeking care is **advanced or open access scheduling**.

As defined by American physician, Dr. Mark Murray, six elements of improving access include:

- Balancing supply and demand
- Reducing backlog
- Reducing the variety of appointment types
- Developing contingency plans for unusual circumstances
- Working to adjust demand profiles
- Increasing the availability of bottleneck resources

The core principle of advanced access is defined as scheduling same-day appointments. However, advanced access is not sustainable if patient demand for appointments is permanently greater than physician capacity to offer appointments.[24]

A study that appeared in BMC Family Practice found that: "Appointments for healthcare could be categorized into *urgent*, *soon* and *elective*. *Urgent* appointments are typically seen as requests for same-day consultations. The *soon* category would fit problems that should be seen within two or three days to prevent escalation or symptom prolongation. Finally, routine or *elective* appointments suit individuals who value an agreed time window over other factors."[25] The study went on to note that advanced access "eliminates appointment categories and the work involved in negotiating urgency by dealing with virtually all demand on the day it arises." But warned: "Too drastic a shift in favour of access is likely to be at the cost of reduced continuity and a diminution of other services, such as screening and chronic disease management."

Another study that examined bookable versus non-bookable (advanced access) appointments found that more patients with bookable appointments saw their physician of choice and that "patients can self-select, with equal satisfaction, the type of appointment that they prefer, dependent upon their own preferences or needs at the time."[26]

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[24] Murray M, Bodenheimer T, Rittenhouse D, Grumbach K, *Improving timely access to primary care: case studies of the advanced access model*. Journal of the American Medical Association (JAMA) 2003 Feb; 289(8): 1042-6.

[25] Wendy Jones et al, *Measuring access to primary care appointments: a review of methods*, BMC Family Practice, 07 July 2003 4:8.

[26] Pascoe SW, Neal RD, Allgar VL. *Open-access versus bookable appointment systems: survey of patients attending appointments with general practitioners*, British Journal of General Practice: The Journal of the Royal College of General Practitioners, 2004 May; 54(502): 367-9.

The Allina Medical Clinic (AMC) in Minneapolis/St. Paul adopted open (or advanced) access scheduling in 1999 and found that more patients saw their own physician. When the AMC launched advanced access, schedulers and physicians reinforced patient-physician matches when patients contacted the office. When patients saw that advanced access didn't impede being seen promptly, patients began asking for their own physician.[27]

With respect to a patient self-selecting the appointment she prefers, this does not help to address patient perception of what she might consider to be urgent or elective. For example, a patient might prefer an urgent appointment because the patient either believes she requires urgent care or she simply wishes to see her family physician sooner.

Advanced access is about doing all of today's work today. In touting advanced access Dr. Murray says "system rigidity improves because appointments don't have to be held or frozen to protect 'same-day' appointments, yet a patient seeking a non-urgent appointment can be seen that day."[28]

In a general practice assessment survey conducted in the United Kingdom, predictably, almost 95% of patients were satisfied with a same-day appointment to see a physician. Only 5% were satisfied waiting longer than five days.[29] An analysis of this general practice assessment study concluded: "Satisfactory standards of access were next day appointments, a 6-10 minute wait for consultations to begin, and seeing the same general practitioner a lot of the time."

A number of countries have looked at advanced access as a system to reduce waiting times for patients accessing primary care and reducing patient backlog by doing today's work today. Below are two case studies conducted in Australia, which demonstrate advanced access in two practice settings.

Case Studies:[30]

A. Group Practice (2003)

Site:
Kooringal Medical Centre, Wagga, NSW (population: 56,000)

Staff:
Four full-time general practitioners, one 0.6 FTE GP and 6.5 FTE administrative staff

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[27] C. Dennis, O'Hare and John Corlett, *The Outcomes of Open-access Scheduling*, American Academy of Family Physicians (downloaded from Family Practice Management website at www.aafamily physician.org/familyphysician) 2004.
[28] Mark Murray, *Waiting for Healthcare: Physician offices can dramatically reduce how long patients wait for appointments*, Postgraduate Medicine Online, 2003 Feb; 113(2).
[29] Bower et al. For a copy of the survey, see: www.gpas.co.uk
[30] Andrew W. Knight, John Padgett, Barbara George and M.R. Datoo, *Reduced Waiting Times for the GP: Two Examples of 'Advanced Access' in Australia*, Medical Journal of Australia, 2005 Jul; 183(2): 101-3.

Situation:

- Low morale among staff
- Waits for routine appointments up to 55 days
- Multitude of appointment types such as emergency spots and special script appointments
- Up to 120 appointments lost each month because patients did not attend (DNA). Staff felt that DNAs were result of patients booking far in advance and forgetting or eventually deciding they didn't need to see a physician.

Moving to Advanced Access:

- DNAs to about 20 per month, freeing up 100 appointments per month
- Physicians seeing patients earlier and were better able to intervene before deterioration
- Freed up practice capacity
- Less time spent triaging patients, explaining unavailability and searching for appointments

B. Solo Practice

Location:
Cootamundra, NSW (population: 7,500)

Staff:
One general practitioner anesthetist, one practice nurse/administrator and 0.75 FTE receptionist/administrator

Situation:

- Physician continually ran late and booked 2 to 3 weeks in advance
- Each day began with some reserved emergency appointment time, but with most of the day booked, extra emergency bookings were squeezed in.
- Staff triaged urgent patients leading to fewer urgent patients getting appointments at the times they wanted.
- If presenting patients required urgent attention, physician had to work longer, often to 8 pm rather than 5 pm.

Moving to Advanced Access:

- Initially, staff worked longer hours to fit all patients in on one day
- But practice adjusted and patients confident that they did not have to book weeks in advance
- Clinic only offers same-day appointments and at the time of the study had sustained that for 8 months
- DNAs were reduced from 10 per month to less than one per month
- Increase in chronic disease care

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