The College of Family Physicians of Canada

Le Collège des médecins de famille du Canada

ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

…And Still Waiting

Exploring Primary Care Wait Times in Canada

April 2008

Discussion Paper

The Primary Care Wait Time Partnership

The Primary Care Wait Time Partnership

was established in 2007 between

The College of Family Physicians of Canada
and
The Canadian Medical Association

with the purpose to explore the complex issues of primary care wait times and to develop evidence-based benchmarks for timely access to primary medical care in Canada.

Contents

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Executive Summary

Access to care is one of the most discussed issues facing the Canadian health care system. To provide more timely access to care, a succession of federal governments – followed by their provincial / territorial counterparts – have committed to wait time strategies that include wait time funding to support the achievement of wait time benchmarks and guarantees. As a further step, wait time registries have been launched so that patients can get on a list and track the waiting period for specific surgical and diagnostic procedures. But the question remains: is access to health care improving for Canadians?

To contribute to these discussions, the Primary Care Wait Time Partnership (PCWTP) is mandated to delve more deeply into primary care wait times and to consider the development of evidence-based benchmarks and/or targets for timely access in primary care. The first of two anticipated reports from the PCWTP, this paper seeks to "scope-out" primary care wait times to stimulate discussion and to seek agreement about ways to improve timely access *to* primary care and *from* primary to more highly specialized care. It is expected that this will lead to another paper in 2008 to further define wait times in primary care.

If access to health care is to be improved both across Canada and also within its regions, meaningful wait time targets and benchmarks must be pan-Canadian, include primary care, and take into account this country's geography and unique health system characteristics.

Few will argue the vital role of the family physician for patients requiring access to health care. This extends to care both within as well as beyond the primary health care system. By neglecting the importance of primary care and the role of the family physician the system fails to acknowledge the full wait time that patients experience. To date, few governments and health authorities have sought ways to measure the full wait time experience, with most measurement beginning not with the family physician but with the patient's visit to the consulting specialist.

There are significant challenges in measuring wait times in primary care at each of the three main patient-physician intersects:

i) Finding a family doctor
ii) Getting an appointment with a family doctor
iii) Being referred, when needed, by the family doctor for more highly specialized investigations or consultations

Canadians have overwhelmingly spoken in favor of access to their own family physician and yet approximately five million do not have one. Over the past several years, strategies have been developed and many are now being implemented to re-connect each Canadian with his or her own family physician. These efforts are contributing to a welcome expansion in capacity for the education and training of family physicians as well as the development of models of care that could prove attractive to family physicians. However, a target needs to be set to ensure that all Canadians have appropriate access to a family physician and subsequently, the rest of the health care system when required.

With fewer family physicians accepting new patients and with a burgeoning baby boomer population that has the potential to increase health care needs, timely access to one's own family physician may be a challenge. The scarcity of family physicians and the workloads that many family physicians carry on a daily basis mean that even Canadians with a family physician may still experience difficulties accessing care.

Improving Access for Patients

Comprehensive, Continuing Care: Continuity and comprehensiveness of patient care are important elements of family practice and are highly valued by both patients and family physicians.

Collaborative Care: Family physicians have a greater capacity to offer more timely access to care when they work together with other health care professionals.

Advanced or Open Access Scheduling: Same-day booking or advanced (or open) access scheduling has been shown in some settings to improve access by: balancing supply and demand; reducing backlogs; reducing the variety of appointment types; developing contingency plans for unusual circumstances; working to adjust demand profiles; increasing the availability of bottleneck resources.

Access After Hours: While the majority of family physicians offer care after regular hours, family practice models are changing to accommodate patients' urgent needs without the onerous obligation of frequent or continuous after-hours coverage. This is being accomplished using collaborative approaches to care either between family physicians, between practices, or involving other professionals such as nurses.

Diagnostic Services: Unfortunately, wait times are lengthened in some communities because access to advanced diagnostic tests is rationed as a way of saving money when in fact, this restriction may force patients to wait in multiple queues. Access to advanced diagnostics should be evidence-based and not restricted on the basis of cost control.

Remuneration: Remuneration models should be examined as one way to encourage better patient access to family physicians. New models with blended funding, incentives and bonuses to support comprehensive, continuing care and other services are essential starts to addressing gaps.

Potential for Primary Care Wait Time Measurement

The role of clinical judgment should not be ignored in striving for more timely access to care. For example, undifferentiated conditions need attention – sometimes urgently – even if they do not fit the criteria for registering patients on wait time lists. Best evidence and clinical expertise should be suitably balanced to ensure flexibility in the management of wait times for patients. It is well to remember that the goal of wait time management is not simply to place patients on wait lists that can be measured. It is to ensure timely access to care.

The Canadian Medical Protective Association (CMPA) recently raised a cautionary signal. The potential medico-legal problems that can arise from setting wait time benchmarks have been noted by the CMPA. The goal of wait time management should not be to determine blame but to measure, set targets or benchmarks and by so doing, make improvements that enable timelier access to care for patients within the health system.

Given these and other considerations, there are short to long-term opportunities to ensure more timely access for patients in primary care by examining three areas of measurement:

- *Data:* The initial requirement for proceeding with primary care wait times is the need to be able to measure and track wait times along the continuum of the patient's care.
- *Benchmarks or Targets:* Given the complexities of measuring primary care wait times, there is also the need to agree to which benchmarks or targets should be attained along the patient's wait time continuum.
- *Guarantees:* Wait time guarantees are a further progression in the development of a health system that provides timelier access to care. A guarantee does more than state a benchmark; it ensures attainment and states the opportunity for recourse if the benchmark is not attained.

1. Introduction

Access to care is one of the most discussed issues facing the Canadian health care system. To provide more timely access to care, a succession of federal governments – followed by their provincial / territorial counterparts – have committed to wait time strategies that include wait time funding to support the achievement of wait time benchmarks and guarantees. As a further step, wait time registries have been launched so that patients can get on a list and track the waiting period for specific surgical and diagnostic procedures. But the question remains: is access to health care improving for Canadians?

In 2007, The College of Family Physicians of Canada (CFPC) and The Canadian Medical Association (CMA) established a partnership to explore wait times in primary medical care – the CFPC-CMA Primary Care Wait Time Partnership (PCWTP). This partnership unites the resources of two of Canada's national medical organizations to examine the breadth of issues related to primary care wait times. The ultimate goal of the Partnership is to advocate for Canadians in seeking timely access to care, including but not limited to: time to find a family physician, time to be seen by one's family physician, and time to be seen by a consulting specialist.

The *Wait Time Alliance* (WTA) under the leadership of the CMA has made bold and concrete recommendations related to wait time benchmarks. Responding to a federal / provincial / territorial (FPT) government focus on five clinical areas (cardiac care, cancer care, cataract surgery, hip/knee replacement surgeries and diagnostic imaging, i.e. MRIs and CTs), the WTA released its report: *It's about time*, containing a number of recommendations for more timely access within these five areas (August 2005). In its paper and also since then, the WTA has recognized the need to broaden measurement to define wait times that include other aspects of care, taking into account the whole wait time experience of patients.[1]

In December 2005, the CFPC issued its *Wait Times Position Statement*. It explicitly stated: "Wait time benchmarks should be developed for the time it takes people to find / identify a personal family physician for their ongoing care, for appointments with a family physician for a given problem, and for appointments for investigations or consultations with other specialists made by family physicians on behalf of their patients."[2]

In November 2006, the CFPC released its Discussion Paper: *When the Clock Starts Ticking – Wait Times in Primary Care*. This paper recommended that wait time measurement start when a patient first seeks care with his or her family physician through to consultation for more highly specialized care, if required. In advocating for improved access to care, the CFPC has been a strong proponent of a broader approach that takes into account: 1) the whole wait time experience, known as the "wait time continuum"; and 2) other clinical areas beyond the five that have recently been the focus of governments.

In May 2007, the *Wait Time Alliance* announced that it was expanding its membership to include: the Canadian Anaesthesiologists' Society, Canadian Association of Emergency Physicians, Canadian Association of Gastroenterology, Canadian Psychiatric Association, and the Canadian Society of Plastic Surgeons. It is expected that this larger membership will draw attention to clinical areas beyond "the five" and address a greater proportion of the wait time continuum.

Many other health organizations and leaders have spoken in favor of the need to include primary care in wait time measurement and to expand the scope of clinical areas being considered. At the *Timely Access to Health Care Conference* sponsored by FPT governments in February 2007, the British Columbia Minister of Health, The Honourable George Abbott, spoke strongly in favor of including primary care in wait time measurement or ignore it at the peril of attaining any wait time benchmarks. Later in April 2007 during the *Taming of the Queue IV* Conference, Prime Minister Stephen Harper announced the

achievement of specified wait time guarantees by all provincial / territorial jurisdictions. This was followed by public comments from the federal Minister of Health, The Honourable Tony Clement, in which he made targeted reference to the federal government's support for wait times in primary care. In its most recent release on wait times, the Health Council of Canada has said that: "unless access improves for health care services not subject to the [wait time] guarantees, the guarantees by themselves may fall short of meeting the expectations of Canadians."[3] In July 2007, a group of international researchers, including Canada's Dr. Jack V. Tu from the Institute for Clinical Evaluative Sciences, published a review of wait time strategies in five developed nations from which they highlighted several key policy implications, the first being the need to extend "the measurement of wait times to include aspects of waiting from the point of referral to treatment …to better reflect patients' actual experiences and provide insights into where critical problems exist."[4]

To contribute to these developments, the Primary Care Wait Time Partnership (PCWTP) is mandated to delve more deeply into primary care wait times and to consider the development of evidence-based benchmarks and/or targets for timely access in primary care. The first of two anticipated reports from the PCWTP, this paper seeks to "scope-out" primary care wait times to stimulate discussion and to seek agreement about ways to improve timely access *to* primary care and *from* primary to more highly specialized care. It is expected that this will lead to another paper in 2008 to further define wait time benchmarks in primary care.

2. Primary Medical Care –Vital to the Patient

Within the context of this paper, **primary care** is defined as first-contact medical care and services provided by family physicians and general practitioners whereas **primary health care** considers the broader determinants of health and includes health service delivery by other professional providers as well. Primary care may also be defined as: "the 'medical home' for a patient, ideally providing continuity and integration of health care… The aims of primary care are to provide the patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives."[5]

Few will argue the vital role of the family physician for patients requiring access to health care. This extends to care both within as well as beyond the primary health care system. By neglecting the importance of primary care and the role of the family physician the system fails to acknowledge the full wait time that patients experience. To date, few governments and health authorities have sought ways to measure the full wait time experience, with most measurements beginning not with the family physician but with the patient's visit to the consulting specialist.

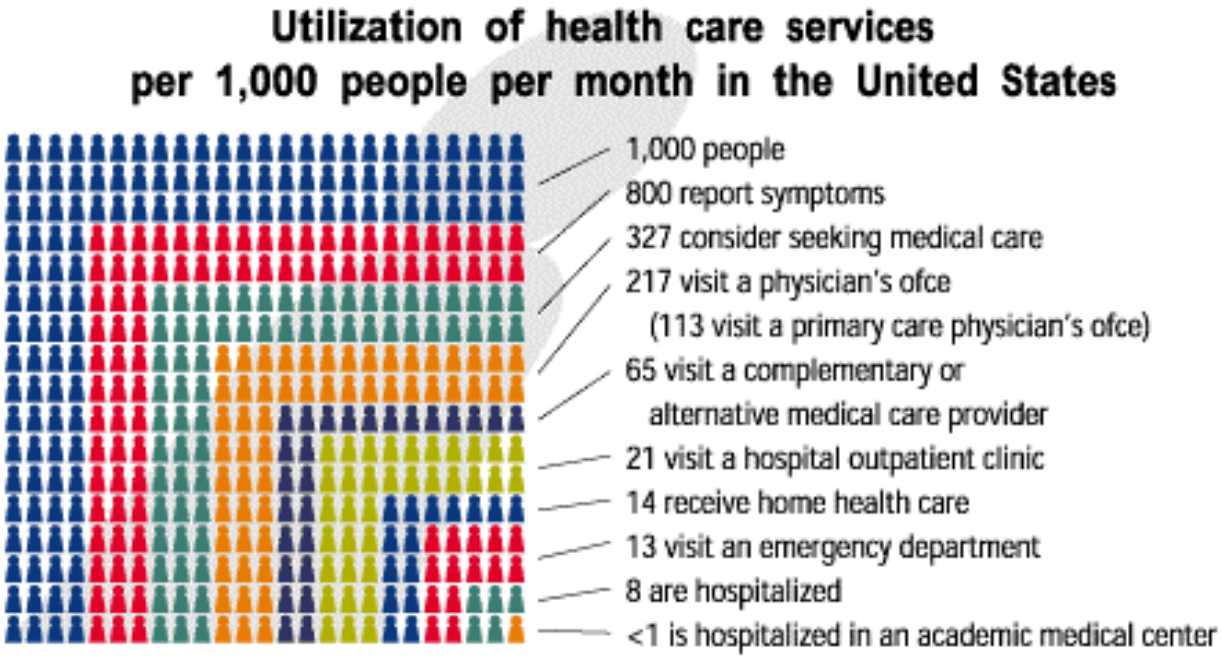
By neglecting the importance of primary care and the role of the family physician the system fails to acknowledge the full wait time that patients experience.

Primary care is the foundation and family physicians are the backbone of the health system as the first points of contact for most patients. When a patient accesses the health system through his or her family physician, the physician may define a list of differential diagnoses or may quickly arrive at a final diagnosis after appropriate examination and/or investigation.[*] For the majority of patients, the final diagnosis is reached by the family physician and does not require the patient to be referred elsewhere. (*See Figure 1*) However, when a complicated diagnosis includes the need for more highly specialized investigations and/or treatment, referral for advanced tests or consultation with other specialists may be required. Canadian patients have always valued the role of their family physician in helping them to navigate all levels of the health care system. In fact, the system is structured to ensure that patients have access to a continuum of medical services by first presenting to their family physician at the primary care level.

Dr. Barbara Starfield, in her internationally acclaimed research, has shown that better health outcomes and lower costs are achieved with a strong primary care system.[6] In their most recent paper, Starfield, Macinko and Shi have shown that adding one more family physician per 10,000 in the population is associated with an average 5.3% reduction in mortality with a positive impact on 49 people per 100,000 over one year.[7] Starfield et al have also demonstrated that the primary care physician supply is positively associated with better population health in three ways: i) improved primary prevention to address issues such as smoking and obesity; ii) earlier detection of disease such as cancer; and iii) improved efficiency in the system because more "family physicians [result in] lower hospitalization rates for conditions that should be preventable or detected early with good primary care (including diabetes mellitus or pneumonia in children and congestive heart failure, hypertension, pneumonia and diabetes mellitus in adults.)"[7]

[*] Differential diagnoses are diagnoses that are considered by the family physician for an individual patient. These diagnoses are listed because they are conditions with similar findings. The final diagnosis is arrived at by determining which condition applies to the patient based on the patient's history, examination(s) and clinical data.

Figure 1



Note: Each box represents a subgroup of the largest box of 1,000 people but is not necessarily a subgroup of the box preceding it in the display.

[†] Cited in "Family Practice Management" American Academy of Family Physicians, September 2001. "The new study updates a 1961 study by White, Williams and Greenberg [*The Ecology of Medical Care*. N Engl J Med. 1961;265:885-892] and shows that, despite substantial changes in the organization and financing of health care, utilization has remained remarkably consistent over the last 40 years." Available from http://www.aafp.org/fpm/20010900/monitor.html; Internet; accessed 13 June 2007.

3. Primary Care – Learning about the United Kingdom

The UK is considered by many to be a global leader in the provision of primary care with 95% of patient contact with the National Health System (NHS) occurring within primary care.[8] In a study by Starfield and Shi rating 13 countries on the development of primary care, the UK rated the highest with a score of 29 out of 30. Canada ranked in the middle with 17.5 and the United States scored 5.5, offering a "low" level of primary care.[9] The concluding findings of Willcox et al on international wait time strategies, suggest: "…England has achieved the most sustained improvement, linked to major funding boosts, ambitious waiting time targets, and a vigorous performance management system."[4] When attempting to improve access to primary care, the drive towards wait time benchmarks must be balanced with high standards and quality of care.

Every British citizen is guaranteed access to a primary care professional within one working day and a general practitioner (GP) within 48 hours or two working days. As defined by the NHS Department of Health, a GP is "**any** general practitioner. This is not a named GP, nor is it necessarily a GP at the registered practice, but is expected to be one who is convenient and easily accessible to patients." A primary care professional is "any health care professional **including GPs**, practice nurses, allied health professionals, other health care staff who is a member of the practice or wider local primary care team, a community pharmacist for instance … one who is convenient and easily accessible to patients."[10]

The Department of Health has recently assessed performance against the 48-hour target by commissioning Ipsos-MORI to survey more than five million patients in GP practices across England. The surveys, released in 2007, yielded 2.3 million responses and found that 86% of people who tried to get a quick appointment with a General Practitioner said they were able to do so within 48 hours. In 43 % of the GP practices 90%+ of patients said they were able to get access within two days.[11]

It should be noted that this guarantee has not been without its challenges. A 2004 review by the Royal College of General Practitioners and the NHS Alliance demanded "more sophisticated [target] indicators that take account of the complexity of primary care provision."[12]

In reviewing a model such as the UK's "24/48", it is prudent to note that there are differences in structure between the NHS and Canada's health system. For example, one factor that is considered an enabler in primary care wait time reductions is the existence of Primary Care Trusts (PCTs) in the UK**.** According to the Department of Health: "Primary care trusts are at the centre of the modernisation of the NHS and are responsible for 80% of the total NHS budget… They work with other health and social care organisations and local authorities to make sure that the community's needs are met."[13]

PCTs are large units, and have been consolidated from 303 in 2005 to 152 presently. It is estimated that there is an average of approximately 330,000 patients per PCT.[14] PCTs also come under the scrutiny of the Healthcare Commission, which is responsible for assessing and reporting on the performance of both NHS and independent health care organizations. In its 2006/2007 Annual Health Check Overview, the Commission has reported that 121 of 152 PCTs had achieved the national target for 48-hour access to a GP while 20 had underachieved and 11 had failed to meet it. Similarly, 120 PCTs had achieved the national target of access to a primary health care professional within 24 hours.[15] It is not known if it is possible to determine what proportion of patients opt to access their GP within 48 hours versus another primary care provider within 24 hours.

One important distinction between primary care in the UK and Canada is that under the terms of the General Medical Services contract, since April 2004 GPs in England have had the ability to opt out of the responsibility for the provision of out-of-hours care by forgoing an average of £6,000 per year. The local PCT then takes responsibility for the out-of-hours service for the GP's patients. A 2007 review by the House of Commons Committee of Public Accounts notes that there has been increasing use of nurses and other health professionals to work with GPs in the provision of out-of-hours services.[16]

In general the UK has had greater flexibility to permit the engagement of nurses and other health professionals in primary care as General Practice has been funded on a capitation basis for decades. More recently this has been enhanced with the introduction of an investment in primary care scheme in 2001 to service improvements such as extending the skill mix of the primary care team.[17]

While the UK in some respects may be considered to have improved access in primary care, including some benefits that follow, the system is still evolving based on the National Health System's own particular characteristics.

Meaningful wait time targets and benchmarks must be pan-Canadian and include primary care, taking into account Canada's geography and unique health system characteristics.

A further distinction between Canada and the UK is that the NHS is subject to the European Working Time Directive, which limits working time to a maximum 48-hour working week (currently 56 hours for doctors in training).[18] It is not known if the impact of the Working Time Directive on access to care has been rigorously assessed.

Space, distance and population density bring unique challenges in access to health care, including primary care. Canada has half the population of the United Kingdom (UK) but 40 times the geographic area.[‡] In some areas of Canada the nearest family physician may be hundreds of kilometres away. To add to geographic challenges, each province, territory and region in Canada often has its own decentralized system of ensuring access to health services with different approaches to funding and accountability. Canada's geography and decentralized health system will continue to pose unique challenges for patients and providers alike in timely access to the health care system through primary care services.

If access to health care is to be improved both across Canada and also within its regions, meaningful wait time targets and benchmarks must be pan-Canadian, include primary care, and take into account this country's geography and unique health system characteristics.

[‡] According to Wikipedia: Canada: 9,970,610 square km; UK: 242,900 square km.

4. The Wait Time Continuum

4.1 Accessing Care – Without a Family Physician

4.1.1 Background

Decima Research and Statistics Canada surveys in 2005 revealed that approximately 14-15% of Canadians did not have a family physician. These were national figures and percentages varied from region to region and community to community. For example, regional data from the 2005 Statistics Canada survey indicated that 24% of Quebecers were without a family physician, while this was the case for only 5% of Nova Scotians. (S*ee Appendix B.*) However, there is evidence that these averages vary significantly even within provinces that appear closer to acceptable levels.

In fact, 2006 survey data revealed that 17% of Canadians, or approximately five million, did not have access to health care through their family physician.[19] Canadians who do not have a family physician to manage and coordinate their care are often called "orphan" patients. Many of these patients rely on episodic care through hospital emergency rooms or community walk-in clinics. Under these circumstances, access to and coordination of care often remains disjointed and fraught with many challenges for the disconnected patient.

4.1.2 Valuing Family Physicians

A 2006 study by Sanmartin and Ross, based on 2003 data, indicated that 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.[20]

Decima Research found that an overwhelming majority of Canadians (88%) in 2004 believed having a family physician allowed them to feel more confident in their ability to access appropriate and timely care. Other studies have confirmed that the majority of Canadians seek access to care through their family physician.[21]

A more recent survey (2005) revealed that when considering all aspects of their health care, 66% of Canadians believed their family physician was the most important person to themselves and their family with 17% reporting other medical specialists.[22]

4.1.3 Ensuring Access to a Family Physician

Canadians have overwhelmingly spoken in favor of access to their own family physician and yet approximately five million do not have one. Over the past several years, strategies have been developed and many are now being implemented to re-connect each Canadian with his or her own family physician. These efforts are contributing to a welcome expansion in capacity for the education and training of family physicians as well as the development of models of care that could prove attractive to family physicians. However, a target has not yet been set to ensure that all Canadians have appropriate access to a family physician and subsequently, the rest of the health care system when required.

Not every Canadian without a family physician is necessarily seeking one. Yet according to the same 2006 survey[19], of those who did not have a family physician, about 40% were looking but could not find

one. However, this percentage is probably even greater because experiential evidence from many Canadians continues to confirm that many do not bother looking because they are aware that there are no family physicians or none with "open practices" in their community. In fact, many community-based family physicians have already extended themselves beyond their service capacities, resulting in practices closed to new patients.

With these considerations in mind, the Primary Care Wait Time Partnership supports the target originally proposed by the CFPC - that 95% of Canadians in each community have a family physician by the year 2012. This figure is a prescription for better access to care and better population health outcomes nationally as well as from each province, region and community. Data from 2006 tell us that some regions of the country may be close to attaining this target while many others are far from it.

Strategies that would help to achieve such a target have been addressed in other documents, including the CFPC's policy paper: *Family Medicine in Canada – Vision for the Future* (2004). For the five million Canadians without a family physician or for those whose family physician might be considering changes in his/her practice, e.g. retiring, downsizing or becoming more focused, there is significant interest in opportunities to increase the percentage of the Canadian population having a family physician.

Unfortunately, the majority of family physicians have reached maximum capacity in their patient loads. This is borne out in the diminishing number of family practices accepting new patients. The National Physician Survey (NPS) found that there were proportionally fewer family physicians accepting new patients in Canada in 2004 than in 2001 – 20.2% versus 23.7% respectively.[23] Coupled with this, family physicians – like many others in the Canadian workforce – are nearing retirement. The average age was 48 years in 2004. As they retire or slow down, there is the potential for more patients to find themselves "orphaned". This will present further challenges in timely access to those family physicians still practicing. Adding to this concern is that orphaned patients are often older people with complex problems requiring longer visits, who are thus more difficult to accommodate in already very busy practices.

Is it possible for family physicians, who are already challenged with full practices, to take more patients without increasing the chance of professional burnout? While a committed relationship between a patient and his or her own family physician is highly valued in practice, changes are taking place to make sure ***a*** family physician is always available to patients, even when the degree of urgency is greater. This may not always be the patient's own family physician but should be one integrally connected to the practice. As the complexity of the health system increases and family practice / primary care models evolve, the challenges of solo practice and increasing opportunities to collaborate in health care delivery are generating more interest in intra-professional care shared between family physicians.

A number of strategies aimed at increasing practice capacity are being introduced or considered by family physicians and health system planners in communities across Canada, including:

- Family physicians working in groups or networks with other family physicians
- Adopting information technology in practice to enable more efficient access to patient information. In 2004 only 14% of Canada's family physicians used electronic medical records compared to 29% in the USA, 64% in Australia, 87% in the Netherlands and 100% in New Zealand.[24] In the UK, computers are integral to general practice with nearly all GPs using them for clinical care.[25] However, it's worth noting that the uptake of newer technologies in the UK is encouraged with ongoing government support through funding and incentives.
- Embracing patient scheduling models such as those used in advanced access scheduling. (*See Appendix C.*)

- Maximizing health human resources within inter-professional teams (family physicians, family practice nurses, nurse practitioners, and other healthcare professionals).
- Shared care management of chronic diseases involving strategic collaborative care provided by family physicians and consulting specialists.

4.1.4 IMGs and Self-sufficiency

Integrating international medical graduates (IMGs) into the health care system has always been part of Canada's health human resource (HHR) strategy. Approximately 23% of physicians currently practicing in Canada are foreign-trained.[26] These physicians are highly valued and ensure access to health care for many Canadians who would otherwise be without a family physician.

While an appropriate mix of national and international medical graduates is healthy for any nation, Canada's HHR planning has become overly dependant upon IMGs to resolve the access to care problems faced by Canadians because of our physician shortages. The CFPC and CMA support HHR policies and strategies that would ensure the right numbers and mix of both Canadian Medical Graduates (CMGs) and IMGs. To achieve self-sufficency will require ongoing commitments to increases in the number of medical students being trained in Canadian Medical Schools.

The 10% reduction in Canadian medical school enrollment recommended by the 1992 Banff Conference of Ministers of Health and subsequently implemented across the country has contributed significantly to our present difficulty by increasing physician shortages. Fortunately, following the recommendation of the Canadian Medical Forum Task Force I on Physician Resources in 1999-2000, governments have supported increases in medical school enrolments. From a post-Banff low of 1577, numbers had increased by 2006 to 2460 entry positions. [27] According to OECD data, in 2003 Canada had 5.3 medical graduates per 100,000 population – the lowest of 25 countries surveyed.[28]

Canada's HHR planning must be an ongoing process that keeps pace with population growth, aging, and the increasing complexity of medical care. It must be committed to ensuring we are educating the right number of physicians in our Canadian medical schools and providing opportunities for the right number of IMGs to be added to the total physician complement. While we must continue to strive for increased self-sufficiency, IMGs will continue to play an important role as valued physicians in our health care system.

4.2 Accessing Care – With a Family Physician

4.2.1 Access to a Primary Care System Under Stress

With fewer family physicians accepting new patients and with a burgeoning baby boomer population that has the potential to increase health care needs, timely access to one's own family physician may be a challenge. The scarcity of family physicians and the workloads that many family physicians carry on a daily basis mean that even Canadians with a family physician may still experience difficulties accessing care. While Sanmartin and Ross found that those without a family physician had more difficulty accessing routine care, they also found that those with a regular family physician were just as likely to experience difficulties in accessing "immediate" care as those without a regular family physician.[29] If Canadians are to receive timely care, access to family physicians must also be timely.

4.2.2 Maintaining and Improving Primary Care Access for Patients

The following sections describe some important elements related to the practice of family medicine:

4.2.2.1 Comprehensive Continuing Care

Continuity and comprehensiveness of patient care are important elements of family practice and are highly valued by both patients and family physicians. In the context of primary care, continuity may be defined as "the relationship between a single practitioner and a patient that extends beyond specific episodes of illness or disease."[30] Comprehensive care may be defined as the case where a single physician (or practice) deals with the full scope of a patient's health care issues over a prolonged period of time. These concepts are embodied in the CFPC's four principles of family medicine.[31]

The CFPC and the CMA support the goal that each Canadian should have his or her own family physician.

In order to help deliver continuing comprehensive care patients may need to be seen at different times by different members of a physician group, including their own personal family doctor – but also by other family physicians who are part of the group or network. Family physicians should be well supported to provide comprehensive care.

Over the past few decades increasing numbers of family physicians have moved to models where they work with one another to ensure comprehensive, continuing care. The main indication of this trend has been the shift from solo to group practice. As of 2007, 51% of family physicians are in group practice, 24% are in interprofessional practice (i.e. with other health professionals with their own caseloads) and 23% are in solo practice.[32] Salaried models such as community health centres have been in existence in several jurisdictions for some time. More recent innovations include Family Health Teams in Ontario, which include interdisciplinary teams of family physicians and other providers[33], and Primary Care Networks in Alberta, which enable family physicians to work more closely with other family physicians and other health professionals.[34]

4.2.2.2 Collaborative Care

Family physicians may have a greater capacity to offer more timely access to care when they work together with other health care professionals. The most appropriate mix and number is unique to each patient and community, depending on the practice population and its needs, availability of health human resources in the community, and in many cases, geographic location of the community itself. Where collaborative care exists, it is extremely important that providers understand and respect each other's roles in order to ensure that patients are able to access the most appropriate provider with the family physician continuing as the clinical leader of their medical care.

Access to primary and other levels of care is impacted by the ease of navigating the health care system. Several new models are emerging across Canada such as Family Health Teams in Ontario, Alberta's Primary Care Initiative, and others.

Just as important for patients – and in some situations, more important than inter-professional care shared between physicians and other providers – is the delivery of intra-professional care between family

physicians themselves or between family physicians and consulting medical specialists. The CFPC and The Royal College of Physicians and Surgeons of Canada recognized that:

> "Collaborative models are being developed in efforts to improve patient care and effective management, not just between physicians and other health care professions, but also between family physicians and other specialists. The work of examining patient outcomes and provider and patient satisfaction relative to these new models of practice is just beginning."[35]

4.2.2.3 Advanced or Open Access Scheduling

Same-day booking or advanced (or open) access scheduling, defined by Dr. Mark Murray, has been shown in some settings to improve access by:

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

Some family practices are implementing timely access models in scheduling patients' visits. The Health Quality Council of Saskatchewan encourages same-day appointments in addition to pre-booked appointments.[36] The Alberta Primary Care Initiative notes that same day access is part of a shift to a new health care access paradigm.[37] A summary of the literature on the experience with Advanced Access is provided in Appendix C. It is noted that a critical assumption of Advanced Access is that the demand for and supply of appointments are in overall balance. Hence it will be important to ensure that demand is balanced with the physician's willingness and ability to provide a specified number of hours of service. British Columbia's "Primary Health Care Charter" notes that "advanced or open-access scheduling is one solution for improving access to primary health care…The Practice Support Program teams being established in BC offer family physicians change packages that include support for the adoption of advanced access scheduling to improve the availability of same day access to service."[38]

4.2.2.4 Access After Hours

According to the NPS, approximately 69% of family physicians provided on-call services in 2004.[39] The NPS also found that for care outside of regular office hours, an alternate on-call physician was available for the patients of 53% of the family physicians surveyed. In Saskatchewan, a national high of 82% said that an alternate physician was available.

While the majority of family physicians offer care after regular hours, family practice models are changing to accommodate patients' urgent needs without the onerous obligation of frequent or continuous after-hours coverage. This is being accomplished using collaborative approaches to care either between family physicians, between practices or involving other professionals such as nurses.

While patients prefer to see their own family physician after-hours, or one connected with their family physician's practice, there is mounting evidence to suggest that nurses can effectively screen and direct patients seeking advice on care during these time periods. Initiatives such as telehealth provide access to after-hours care in urban, remote and rural communities.

4.2.2.5 Diagnostic Services

According to Statistics Canada, 58% of patients in 2003 waited less than a month for certain diagnostic tests, one in three waited between one and three months, while 12% reported waits in excess of three months.[§, 40] This report also noted that "despite some variation across provinces in the proportion of individuals who waited more than three months, none of the provincial rates was statistically different from the national level rate. [However]…approximately one in five individuals who waited for a diagnostic test reported that their waiting time was unacceptable." Barriers included: waiting too long for tests, waiting too long for appointments, and difficulty getting an appointment.

The WTA recommended a benchmark of four weeks for access to advanced diagnostic tests such as MRIs and CT scans. According to another recent WTA report, waits for these services continue to remain lengthy despite significant investments in diagnostic imaging over the past few years.[41]

The majority of responsibility for patient care rests on the shoulders of the family physician and does not require referral to more highly specialized care. However, in some settings, some diagnostic tests cannot be accessed by family physicians – often as a cost control strategy. The result may be patients waiting in multiple queues. If family physicians had better access to advanced diagnostic services, referrals to other specialists could be timelier – or reduced. In reality, some patients are referred to consulting specialists simply because of lengthy waits or lack of access to diagnostics.

Unfortunately, wait times are lengthened in some communities because access to advanced diagnostic tests is rationed as a way of saving money when in fact, this restriction may force patients to wait in multiple queues. Access to advanced diagnostics should be evidence-based and not restricted on the basis of cost control.

4.2.2.6 Remuneration

Prior to 2004, over half of Canada's family physicians received greater than 90% of their incomes from fee-for-service.[39] But if given a choice, 75% of family physicians would prefer a system of blended payments.[**] Remuneration models should be examined as one way to encourage better patient access to family physicians. New models with blended funding, incentives and bonuses to support comprehensive, continuing care and other services are essential starts to addressing these gaps. Some of the barriers to improved access in primary care might be overcome by:

- Incentive payment models
- Changes in remuneration for indirect[††] patient services provided by family physicians as well as other specialists
- Methods of remuneration that promote collaborative care as well as comprehensiveness

[§] Diagnostic tests include non-emergency MRIs, CT scans and angiographies – not x-rays and blood tests.
[**] Blended payment captures those cases where physicians' were paid by two or more methods, with no single method comprising 90+% of remuneration.
[††] Indirect services are those services performed outside the face-to-face patient-physician encounter such as telephone consultations that are uncompensated.

4.3 Accessing Care – To Highly Specialized Services and Consulting Specialists

4.3.1 Beyond "The Five"

Across Canada, most wait time measurements focus on the time between a patient's consultation with a specialist who is not a family physician, e.g. a cardiologist, to the point at which the patient receives treatment, e.g. heart surgery. This wait time period, while important, does not represent the patient's full wait time experience.

In addition, most wait time measurement has been limited to those clinical areas originally identified by government – all highly specialized areas – and even then only specific procedures within the five. Patients of course are concerned about the waits they are experiencing for a much broader range of medical problems – concerns they share with their family physicians.

According to the Decima survey of 2006, about one in two family physicians said that the wait time to consultation for their patients was unreasonably long, proving to be their most significant frustration.[42] The top five clinical areas in which family physicians experienced this frustration were: orthopaedics, neurology, psychiatry, gastroenterology and dermatology. The next phase of the work of the WTA is focused on some of these clinical areas but there continues to be many others that require wait time consideration. Critical to all medical problems being studied is the need to focus on the elements of the wait time that are experienced within the realm of primary care/family practice. To date these have been ignored.

4.3.2 Dilemma – How Far beyond the Five?

At present, most wait time benchmarks have been developed for only specific procedures or diagnostic interventions within the five originally defined areas. In order to expand wait time measurement to primary care, there should be consideration for wait times that include a much wider variety of diagnoses and diagnostic interventions. Recognizing the numerous conditions that family physicians manage in practice, the dilemma is how many, which ones, and in what state of diagnostic differentiation – given that one of the key functions of primary care is to take the patient from undifferentiated symptoms to a well-differentiated diagnosis.

For which clinical areas are wait time benchmarks most needed? How can primary care interventions be measured? Building on the Decima and CFPC surveys conducted in 2006, the following clinical areas were considered a priority for both patients and family physicians trying to access more highly specialized services and consultations:

- Cardiology
- Dermatology
- Gastroenterology
- Gynaecology
- Neurology
- Oncology
- Ophthalmology
- Orthopaedics
- Paediatrics
- Psychiatry
- Rheumatology

This is a lengthy list and in fact, there are probably many other clinical areas that could be considered, leading to further conjecture that perhaps wait time indicators ought to be applied to more generalized ***diagnostic groups*** as well as specific diagnoses to which they have been applied to date. Wait time indicators should also continue to respect the perspective of the patient as well as the provider when waiting for the next stage in care.

Patients with problems presenting in primary care, including undifferentiated symptoms, deserve and need to be seen in a timely manner. This could be based on level of urgency – not the specific clinical area of the problem. For example, urgent problems might be seen in 12-24 hours while non-urgent ones in 48-72 hours. In terms of access, the focus should be on access ***to*** primary care (i.e. the family physician) and ***from*** primary care (i.e. to more highly specialized services and consultations). For referrals, there could be a limited, but expanding number of conditions for which there are wait time benchmarks for a patient to enter a wait list (i.e. for the clock to start ticking). The patient would have to meet standardized criteria (developed by family physicians and other specialists). If the criteria are met, the clock starts. If there is need to give credit for time spent prior to confirmation of the diagnosis – then the clock start time should be pushed back. For example, if a general surgeon confirms that gall bladder surgery is necessary, but the family physician has received an ultra-sound report indicating the presence of stones in a symptomatic patient several weeks prior to the consultation, the clock should be deemed to start once the family physician has reviewed the ultra-sound report and requested the consultation.

5. Primary Care Wait Times – Monitoring the Full Continuum of Care

5.1 Measuring the Full Continuum of Care

For the most part wait time measurement in Canada today covers the time period from the patient's visit to a consulting specialist to definitive treatment by that specialist. The continuum of the patient's wait time experience is ignored when wait times are measured this way.

Throughout the journey in the continuum of care, there are several stops where a patient may encounter significant waits (*Figure 2*):

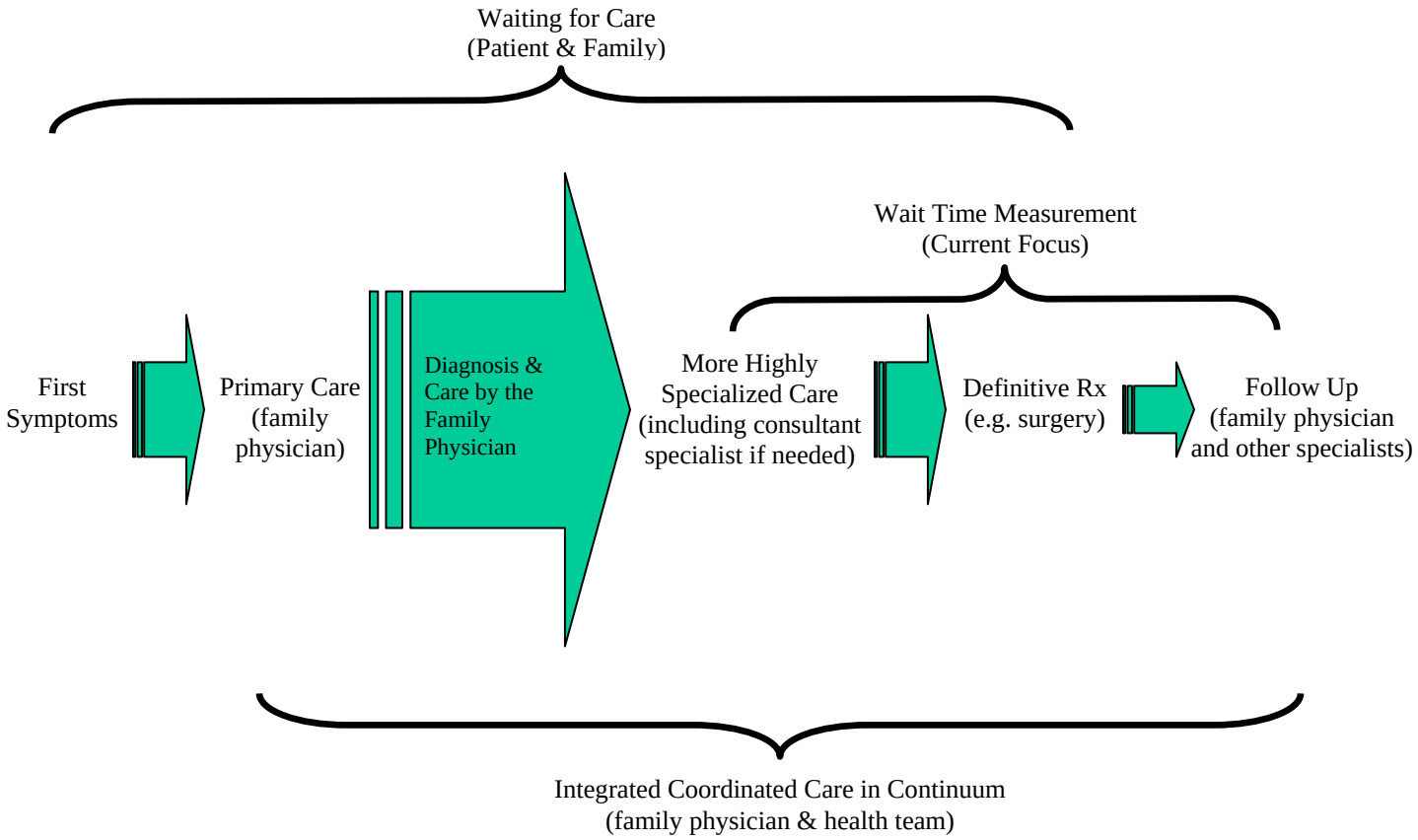
- Finding a family physician
- Seeing a family physician for initial and ongoing investigation, diagnosis and treatment
- Accessing diagnostic tests
- Being referred to a consulting specialist for further assessment or advice if required
- Receiving medical or surgical treatment, other specialized procedure or investigative intervention from the consulting specialist
- Follow up with the family physician and/or consulting specialist – e.g. for rehabilitation or ongoing chronic disease management

As shown by Green et al (*Figure 1)*, the overwhelming majority of patients do not require medical services beyond primary care /family practice. Yet the most highly profiled initiatives in wait time benchmarking and management have ignored trying to define reasonable times for patients to find a family physician, be seen by the physician they have, or be referred when necessary from their family doctor to a consulting specialist.[43]

If Canadians are to receive timely access to primary care and beyond, there will need to be decisions about optimum access to care along the wait time continuum. Every Canadian should have access to a family physician, timely access to their family physician, and wait time benchmarks should be set for patients to be seen by consulting specialists as well – beyond the five clinical areas of recent focus. For all of these, the urgency of care will impact the determination of the most appropriate wait time benchmark for access to care.

Figure 2 illustrates the route of patients along the medical care pathway, including all the points at which waiting can and should be measured.[44]

Figure 2



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

5.2 Managing Primary Care Wait Times – the Challenge

There are significant challenges in measuring wait times in primary care at each of the three main patient-physician intersects:

i) Finding a family doctor
ii) Getting an appointment with a family doctor
iii) Being referred, when needed, by the family doctor for more highly specialized investigations or consultations

The issues related to finding a family physician or getting timely appointments with one's family doctor were addressed in Sections 4.1 and 4.2. Multiple factors need to be addressed to ensure patients have access to family physicians, including producing and retaining more family physicians, and developing models of practice that support family physician in practice.

The CFPC and CMA recommend that:

i) Every Canadian should have the opportunity to have a personal family physician.
ii) There should be a pan-Canadian health human resource planning process that continuously monitors the number and specialty mix of physicians needed to ensure that Canadians have timely access to family physicians and other specialists.
iii) There must be sufficient undergraduate and postgraduate positions for Canadians to pursue medicine as a career in Canada, and capacity in the postgraduate training system to integrate qualified international medical graduates who are permanent residents of Canada into the medical workforce.
iv) Remuneration for family physicians must be increased to ensure equity with other specialties and to create incentives for the provision of essential elements of primary care/family medicine needed by Canadians.
v) Support should be provided for primary care/family practice settings to ensure that optimal models of practice include access to EMRs, interprofessional teams, and delivery of continuing comprehensive care.
vi) Patients should have access to timely appointments with family physicians for medical problems. Wait time benchmarks should be established for appointments for medical problems based upon urgency.

5.3 Managing Urgency of Care

Urgency of care is an issue that determines how fast the clock should tick. Urgency must also be considered when measuring primary care wait times. To date the wait time agenda has largely ignored the waiting time from referral by the family physician to the initial consultation by the specialist. For example, the common benchmarks agreed to by Health Ministers in 2005 state that: "a wait time begins with the booking of a service, when the patient and the appropriate [i.e. specialist] physician and patient agree to a service and the patient is ready to receive it."[45] The shortcoming of this omission is underscored by the results of the Fraser Institute's 2007 annual waiting list survey. According to this survey the total waiting time between referral from GP and treatment, averaged across 12 specialties and 10 provinces, is now 18.3 weeks. Roughly one-half (9.2 weeks) of this total wait is due to the wait between the GP referral and the initial appointment with the specialist.[46] The waiting time from family physician referral has been recognized in the most recently developed benchmarks by the Wait Time Alliance, which include time from referral in the benchmarks for psychiatric care, gastroenterology and anesthesiology (pain management).[47]

At least three distinct levels of urgency have been defined: emergent, urgent and scheduled. The WTA defines these levels of care as follows:

- **Emergent:** immediate danger to life, limb or organ.
- **Urgent:** unstable and with the potential to deteriorate quickly and/or result in an emergency admission
- **Scheduled:** involving relatively minimal pain, dysfunction or disability (also called "routine" or "elective")[1]

Of course, these broad levels can be further segmented. For example, screening and prevention, a very important part of primary care management by family physicians, is obscurely hidden under "routine" or "elective."

Which level of urgency fits may depend on the acuity of the patient's presenting symptoms or diagnosis. The family physician is not in a position to determine the need for/urgency of referral without seeing the patient. Levels of urgency are crosscutting, regardless of the degree of diagnostic differentiation that has been achieved in managing the patient through primary care. A condition does not need to be well-differentiated[‡‡] to be classified as urgent.

5.4 Appropriateness and Responsibility

When delving further into primary care wait time measurement, two other factors should be considered in setting benchmarks: ***appropriateness*** and ***responsibility***.

With respect to ***appropriateness***, a number of questions have already been raised by others involved in wait time measurement and they apply equally well in primary care:

- Who should be placed on a wait time list?
- When should a patient be placed on a list?
- What diagnostic criteria or guidelines should be used?
- Did the clock start ticking before this encounter?
- When or how should a patient come off a list?
- Do patients start at the beginning if placed back on the list?
- Who is responsible to track the list for patients?

Family physicians and other specialists also recognize that managing a patient in a wait time continuum is associated with added ***responsibilities*** that are not necessarily only those of the physician(s) caring for the patient. In determining timely access to care for patients and in tracking their wait times, a number of responsibilities may be considered. These include:

- Addressing patient expectations
- Meeting diagnostic criteria
- Assigning levels of urgency
- Helping patients register on a list
- Tracking the progress of patients on lists
- Managing patients when the wait time benchmark is not attained
- Managing patients' clinical conditions and complications in spite of the "crowding out" effect in the system

In three 2007 publications, the Canadian Medical Protective Association (CMPA) has cautioned physicians about the potential liability risks that may be associated with the management of patients on waiting lists in relation to wait time benchmarks. First, a March 2007 Information Letter raised the concern that while benchmarks might be intended to be performance goals for the system, they might be interpreted by the courts as standards for medico-legal purposes, and that physicians need to consider how to manage patients while they are on waiting lists in order to discharge the duty of care that may be implied by benchmarks.[48] Second, an August 2007 discussion paper raises further concern about medical association activity in establishing benchmarks that might be used as rigid standards by the courts.[49] The paper details eight specific steps for referring physicians to follow in order to monitor/manage patients on waiting lists:

[‡‡] For example, this might refer to the distinction between a patient with diagnosed hypertension coming in for a follow-up versus a patient with dizziness coming in for assessment.

- Note appointment date and determine if timing may be of significant clinical concern;
- Consider appropriate care for patient during waiting period;
- Inform patient about signs/symptoms indicating need for additional care;
- Communicate changes in clinical condition to consultant;
- Try to negotiate earlier appointment/alternate referral if warranted;
- Document clinical assessment and any attempt to arrange earlier appointment;
- Monitor patients and re-prioritize queued patients; and
- Communicate patients' needs to institutions, consultants and others.

Third, a September 2007 information sheet addresses the issue of liability when health-care resources such as specialist care are limited. The sheet notes that physicians may be requested to provide care outside their area of expertise when resources are scarce. While noting that the courts have yet to address this issue it suggests that "courts will not evaluate your decisions against a standard of perfection. Rather your decisions will be evaluated in light of what a reasonable and prudent physician like you would have decided in similar circumstances."[50] Nonetheless, given that the decision to refer implies that a physician has determined that a problem is beyond his/her scope of practice, the issue of support for the physician managing what might be long waits for specialty care will need to be addressed.

As the wait time management issue moves from "benchmarks" and "targets" to "guarantees", as noted in the establishment of the *Patient Wait Times Guarantee Trust* in the 2007 federal budget, such considerations will take on greater importance.

6. The Potential for Primary Care Wait Time Measurement

The factors that must be considered in measuring wait times in primary care are multiple and varied. The issues presented in this paper raise many possibilities for setting wait time benchmarking and/or targeting in primary care; but equally, many uncertainties and challenges.

The role of clinical judgment should not be ignored in striving for more timely access to care.

The role of clinical judgment should not be ignored in striving for more timely access to care. For example, undifferentiated conditions need attention – sometimes urgently – even if they do not fit the criteria for registering patients on wait time lists. Best evidence and clinical expertise should be suitably balanced to ensure flexibility in the management of wait times for patients. It is well to remember that the goal of wait time management is not simply to place patients on wait lists that can be measured. It is to ensure timely access to care.

Governments and other health system leaders should also not lose sight of the fact that patients value continuity of care even if wait times are delayed. For example, patients value being followed by their family physician through a wait time continuum, ensuring as timely access to care and service as possible along a continuum of care until definitive treatment has been achieved and/or ongoing management has been determined.

Co-morbidities, i.e. other illnesses associated with a patient's medical condition, must also be considered when managing wait times. While co-morbidities often influence decisions about the most accurate diagnosis or best course of treatment, they can be expected to also influence wait time measurement through the diversity of conditions, differentiation and levels of urgency that present to family physicians in caring for any one patient.

Given these and other considerations, there are short to long-term opportunities to ensure more timely access for patients in primary care by examining three areas of measurement:

i) Data

The initial requirement for proceeding with primary care wait times is the need to be able to measure and track wait times along the continuum of the patient's care. The capacity and capability of the Canadian health care system to measure wait times in primary as well as more highly specialized levels of care is still very limited – especially from a pan-Canadian perspective. Yet, it is wise to note what was stated in the Wait Time Alliance report: "The setting of wait time benchmarks must be evidence-based but not evidence-bound."[1] The need to provide patients with timelier access to care, including primary care, should not be abandoned or deferred because best evidence may be uncertain or missing. A starting point is to agree to what will be measured in primary care.

Over the past few years there has been a significant increase in the breadth and coverage of population-based surveys that have included measures of access to primary care. For example, the Canadian Institute for Health Information initiated a *Pan-Canadian Primary Health Care Indicator Development Project* that developed a comprehensive set of 105 indicators. Several of these indicators are directly related to access to primary health care (PHC), e.g.:

- Percentage of population who currently have a regular PHC provider, by type;

- Percentage of population over age 18 experiencing difficulty obtaining routine or ongoing PHC from their regular provider in the past 12 months;
- Percentage of population over age 18 experiencing difficulty obtaining immediate care for an emergent but minor health problem from their regular PHC provider on evenings and weekends; and,
- Percentage of PHC clients/patients over age 18 who are satisfied with wait times to obtain appointment for emergency but minor health problems and non-urgent routine care.[51]

It could be expected that the implementation of electronic information and scheduling systems in family practice might enhance the ability to monitor wait times on an ongoing basis.

ii) Benchmarks or Targets

Given the complexities of measuring primary care wait times, there is also the need to agree to which benchmarks or targets should be attained along the patient's wait time continuum: 1) to find a family physician; 2) to be seen by a family physician; and 3) to have a diagnostic intervention or to be seen by a consulting specialist. More specifically:

1) Should a target for all Canadians to find a family physician be set and agreed to by governments and all other stakeholders?
2) For those Canadians who have a family physician, should consideration be given to wait time targets or for access to a family physician and how should these complement access to other aspects of primary care?
3) Should benchmarks also be considered for access to more highly specialized care through the primary care system?
4) How should a wait time system be designed to support family physicians in maintaining and improving patient access to primary care?
5) Finally, targets or benchmarks need to be considered for a wider variety of clinical areas – beyond "the five" – when referrals for advanced diagnostic interventions or consultations are required. Given the capacity and resources of the Canadian health system, which benchmarks and how far should we go in creating patient and provider expectations for timely access to care?

iii) Guarantees

Wait time guarantees are a further progression in the development of a health system that provides timelier access to care. A guarantee does more than state a benchmark; it ensures attainment and states the opportunity for recourse if the benchmark is not attained. As such, the CFPC and CMA have both expressed concerns about establishing wait time guarantees before the necessary health system supports are in place to manage capacity as well as patient and provider expectations.

The goal of wait time management should not be to determine blame but to measure, set targets or benchmarks and by so doing, make improvements that enable more timely access to care for patients within the health system.

Conclusion

As witnessed over the past few years, governments and health system stakeholders seem to be moving from a position that focuses access to care on only specific components of care to a more inclusive approach. The position of the CFPC and CMA is that access to care must be measured throughout the wait time continuum that patients and providers experience. This most definitely includes primary care where family physicians play key roles in clinical decision-making related to access for patients to various aspects of the health care system. And it includes a much broader diversity of clinical conditions.

If wait times are to be suitably measured and to include the patient's experience, primary care is a very important part of that measurement. Yet as this paper identifies, there are many factors to consider before establishing primary care wait time targets or benchmarks. Family physicians themselves may well view wait time management in primary care with some caution if the necessary supports are not in place to ensure targets or benchmarks can be met.

The next stages of wait time development in primary care will involve the need to collect and manage data and to move to solutions that enable the attainment of wait time benchmarks through more timely access to primary as well as other levels of care. This journey must begin with every Canadian having a family physician.

Appendix A

Primary Care Wait Time Partnership

Mandate

The mandate of the Primary Care Wait Time Partnership (PCWTP) is to explore the complex issues of primary care wait times and to develop evidence-based benchmarks for timely access to primary medical care, including, but not limited to the following:

- time to find a family physician;
- time to be seen by one's family physician;
- time to be seen by consulting specialist.

Consideration may also be given to the assessment/recommendations of tools and guidelines to enhance timely access to primary medical care.

Composition

The PCWTP is led by a Steering Committee comprised of members from The College of Family Physicians of Canada (CFPC) and the Canadian Medical Association (CMA) and supported by staff from both organizations.

Co-Chairs:
Dr. Tom Bailey (CFPC)
Dr. Lydia Hatcher (CMA)

Members:
Dr. Robert Boulay (CFPC)
Dr. Shireen Mansouri (CMA)
Dr. John Tracey (CMA)
Dr. Ruth Wilson (CFPC)

Staff:
Dr. John Maxted (CFPC)
Mr. Owen Adams (CMA)
Mr. Eric Mang (CFPC)

Appendix B

Access to a Family Physician – Federal, Provincial and Territorial Data

	Statistics Canada* (2005)		Decima‡ (2005)	
Geography	**With a Regular Family Physician (%)**	**Without a Regular Family Physician (%)**	**With a Regular Family Physician (%)**	**Without a Regular Family Physician (%)**
Canada	86.4	13.6	85	15
Newfoundland and Labrador	89.0	11.0	94	6
Prince Edward Island	89.9	10.1	*Atlantic Provinces surveyed as a region*	*Atlantic Provinces surveyed as a region*
Nova Scotia	95.1	4.9		
New Brunswick	92.6	7.4		
Québec	75.7	24.3	76	24
Ontario	91.6	8.4	90	10
Manitoba	84.0	16.0	81	19
Saskatchewan	84.8	15.2	*MB/SK surveyed as a region*	*MB/SK surveyed as a region*
Alberta	84.2	15.8	86	14
British Columbia	89.8	10.2	86	14
Yukon Territory	76.1	23.9	NA	NA
Northwest Territories	53.0	47.0	NA	NA
Nunavut	12.6	87.4	NA	NA

***** Statistics Canada (2005)

- Population reporting a regular family physician, household population aged 15 and over, Table 105-3024
- Canadian Community Health Survey (3226) – Health Services Access Survey (5002)
- *Adapted from Table 105-3024*: http://cansim2.statcan.ca

‡ Decima Research

- November 25, 2004: **16%** of Canadians reported that they did not have a family physician[§§]
- December 9, 2005: **15%** reported that they did not have a family physician[***]
- November 2, 2006: **17%** reported that they did not have a family physician[†††]

[§§] Between September 11-21, 2004, Decima Research Inc. conducted a national telephone survey of 2,035 Canadians over the age of 18 years. This survey has a confidence level of +/- 2.2% 19 times out of 20

[***] Survey of 2000 adult Canadians was conducted by Decima Research between October 13 and 24 of 2005. The research is considered accurate +/- 2.2%, 19 times out of 20.

[†††] From September 14 to 17, 2006, Decima Research Inc. conducted a national telephone survey of 1,019 Canadians over the age of 18 years. The survey has a confidence level of +/- 3.1% 19 times out of 20.

Appendix C

Advanced (Open) Access

Background

Advanced Access (AA) was pioneered in the United States by Dr. Mark Murray, in collaboration with the Institute for Healthcare Improvement (IHI). It is based on the application of queuing theory, much in the same way it has been applied in the automotive industry to achieve "just-in-time" delivery on the assembly line. The main premise of AA is that if patient demand for appointments is overall in balance with the physician capacity to schedule appointments, it should be possible to offer patients an appointment on the same day that they telephone for one. Murray and colleagues have identified six steps in implementing AA: 1. Measure and balance supply and demand, 2. Eliminate the accumulated backlog. 3. Reduce the number of appointment types. 4. Develop contingency plans (e.g., flu season). 5. Reduce and shape demand (e.g., phone and e-mail for answering questions). 6. Increase effective supply by delegating tasks.[52] The sentinel indicator that is used to monitor AA is what is termed "third next available appointment" and is defined as the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a physical exam.

Research on Advanced Access

The existing literature was compiled by searching Pubmed and Google using the terms "advanced access" or "open access" in combination with the keyword "primary". Some 16 empirical studies were identified (*Table 1*). Among the 16 studies, there was only one small controlled trial; of the remainder, there were two observational studies of multiple units, 11 observational case studies and two qualitative studies. By far the strongest finding is the impact of AA on reduced mean waiting time to third available appointment. Eleven of the 16 studies reported either significant reductions in wait time to third next available appointment or an increase in the proportion of same-day appointments. Six of the 16 studies reported increases in continuity of care (i.e., patient seen by their own physician). Six studies reported increases in patient satisfaction, which were attributed both to decreased wait times and improved continuity, while one reported a decrease in patient satisfaction, perhaps due to an increase in patient wait time at the time of appointment. Three studies showed increased satisfaction among office staff and one found mixed results. Two studies reported increased physician satisfaction while two showed mixed results. Of particular interest to the Canadian context are the findings reported of increased capacity resulting from the implementation of AA either through more new patient visits[53] or increased market share; [54] a reduction of no-show appointments and a demonstration that AA can work in solo practice[55]; and one study reported fewer urgent care services.[56]

The fact that Murray's first paper in the Journal of the American Medical Association appeared in 2003 is doubtless one reason for the small evidence base.[52] Nonetheless, the studies identified provide compelling evidence that AA can result in a reduction in waiting times in a wide array of settings. From the point of view of replicability there are now fairly standardized measurement tools that can be used to measure demand, and the stepwise methodology has been well documented. The evidence base is lacking however, in documenting the costs of implementing AA, particularly in the areas of eliminating the backlog of appointments and the specific measures taken to reshape demand

The implementation of AA can be facilitated through the use of the Breakthrough Series Collaborative (BSC), also pioneered by IHI. The BSC works by bringing together a number of teams to pursue

improvement in a focused topic area and involves eight steps that begin with topic selection, faculty recruitment and enrolment, followed by face-to-face meetings and local implementation and concluding with summative assessments and measurement collaboration.[57] This has been used widely in AA implementation, and a virtual collaborative via Internet and telephone has been developed as well.[58] The BSC approach was used to launch the Primary Care Collaborative among 20 Primary Care Trusts in the UK in 2000 and as of 2003 more than 2000 practices were participating.[59] The Health Quality Council (HQC) of Saskatchewan launched a Chronic Disease Management Collaborative in November 2005 involving 33 family physician practices and 400+ health professionals. Improved access is part of this collaborative and a recent progress report shows positive results in terms of reduced waiting time.[60] This collaborative is being implemented through the facilitation of knowledge exchange consultants of the HQC. Forty new practices entered the second wave in November 2006. Elsewhere in Canada, the adoption of AA in a primary care practice in Penticton BC was presented at the *Taming of the Queue* wait time conference in March 2006[61], and implementation of AA in the Chinook Primary Care Network in Alberta was presented at the national *Conference on Timely Access to Health Care* in February 2007.[37]

Table 1

Open/Advanced Access: Findings from the Literature

Study	Outcomes					
Reference	**Reduced Wait Time for Appts.**	**Increased Continuity of Care**	**Increased Patient Satisfaction**	**Increased Office Staff Satisfaction**	**Physician Satisfaction**	**Other**
Controlled Trial Belardi, F, Weir S, Craig F. A controlled trial of an advanced access appointment system in a residency family centre. Family Medicine 2004; 36(5) 34-5.	√	√				
Observational Multiple Units Pickin M, O'Cathain A, Sampson F, Dixon S. Evaluation of advanced access in the National Primary Care Collaborative. British Journal of General Practice 2004; 54:334-40.	√				√	
Goodall S, Montgomery A, Banks J, Salisbury S, Sampson F, Pickin M. Implementation of advanced access in general practice: postal survey of practices. British Journal of General Practice 2006; 56(533): 918-23.	√					• fewer than one-half of practices were fully using advanced access
Observational Case Study Murry M, Tantau C. Same-day appointments: exploding the access paradigm. Family Practice Management 2000; 7(8):45-50.	√	√				
Pierdon S, Charles T, McKinley K, Meyers L. Implementing advanced access in a group practice network. Family Practice Management 2004; 11(5): 35-8.	√		√			• % of new patient visits increased by 33% between 1st and 2nd year of implementation • physician productivity increased by 8%
O'Hare C, Corlett J. The outcomes of open-access scheduling. Family Practice Management 2004; 11(2): 35-8.		√	√			

Reference	Reduced Wait Time for Appts.	Increased Continuity of Care	Increased Patient Satisfaction	Increased Office Staff Satisfaction	Physician Satisfaction	Other
Anderson J,* Sotolongo C. Implementing advanced access in family medicine: a new paradigm in primary care. North Carolina Medical Journal 2005; 66(3): 223-5 * possible that one practice may overlap with Bundy et al below.	√		√	√		• market share of practice had grown
Meyers M. Changing business practices for appointing in military outpatient medical clinics: the case for a true "upon access" appointment scheme for primary care. Journal of Healthcare Management 2003; 48(2):125-39.	√					• phone system inadequate for call volume
Bundy D, Randolph G, Murray M, Anderson J. Open access in primary care: results of a North Carolina pilot project. Pediatrics 2005; 116(1): 82-7.	√		√			
Knight A, Padgett J, George B, Datoo M. Reduced waiting times for the GP: two examples of "advanced access" in Australia. Medical Journal of Australia 2005: 183(2):101-3.		√	√	√		• the number of no-show appointments dropped from 120 per month to 20 per month
Parente D, Pinto B, Barber J. A pre-post comparison of service operational efficiency and patient satisfaction under open access scheduling. Health Care Management Review 2005; 30(3): 220-8.	√	√	**Decreased**			• patient wait time increased by 2.1 minutes • number of minutes with doctor decreased (possibly due to increased continuity)
Steinbauer J, Korell K, Erdin J, Spam S. Implementing open-access scheduling in an academic practice. Family Practice Management 2006; 13(3):59-64.	√		√	**mixed**	**mixed**	• monthly patient visits increased 20% • 33% increase in call volume (linked to increased patient volume) • 36% reduction in rescheduling of appts.
Solberg L, Crain A, Sperl-Hillen J, Hroscikoski N, Engebretson K, O'Connor P. Effect of improved primary care access on quality of depression care. Annals of Family Medicine 2006; 4(1): 69-74.	√	√				• increased persistence of 6-month anti-depressant medication associated with improved continuity
Rohrer J, Bernard M, Naessons J, Furst J, Kircher K, Adamson S. Impact of open-access scheduling on realized access. Health Services Management Research 2007; 20(2): 134-9.					√	• the hypothesis that a continuing patient would receive more than one primary care visit per year in an open-access clinic was only partially supported.
Qualitative Studies Murray M, Bodenheimer T, Rittenhouse D, Grumback K. Improving timely access to primary care: case studies of the advanced access model. JAMA 2003; 289(8): 1042-6.	**mixed**					• all practices had trouble reducing the backlog • benefits come more quickly for management for MDs
Ahluwalia S, Offredy M. A qualitative study of the impact of the implementation of advanced access in primary health care on the working lives of general practice staff. BMC Family Practice 2005; 639 doi:10 11861 Accessed January 20, 2007.				√	**mixed**	

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