

## COMMENTARY

# Board Accountability Is the Key to Ensuring Timely Access

Peter A.R. Glynn

BAKER AND SCHWARTZ have done an excellent job of clearly laying out the challenges confronting Canadian healthcare providers in ensuring timely access to care. Baker and Schwartz identify three approaches that various jurisdictions have used to improve access to care:

1. measuring and monitoring wait times
2. improving and expanding selected services
3. system redesign

Most importantly, the authors have identified “system redesign” as the key strategy that will provide both sustainability and affordability. They clearly and correctly identify that, in accordance with experience in other jurisdictions, “the greatest gains will come from addressing system redesign to improve the delivery and coordination of care.”

In Canada, a number of provinces, Saskatchewan in particular, have made considerable progress in accurately measuring wait times for surgery. Also, Nova Scotia has started innovative work in measuring and monitoring access time for referrals from family practitioners to specialists. Most provinces have moved to improve and expand selected services; however, broad-based system redesign is not yet a primary strategy. In my view, the problem lies in the fact that we have never been clear on who or what is accountable for timely and appropriate access. By and large, we function in a rather old model of the hospital or regional health authority (RHA),

providing the “physicians workshop,” but having little concern with whom the physician serves in the workshop. As an example, until recently, hospitals had no idea how many patients were waiting for surgical procedures, and they had little idea of the wait time for such access or the variation in wait time between individual surgeons. Currently, only a few hospitals, for example, Kingston General Hospital, The University Health Network and the Saskatchewan RHAs, have accurate knowledge of access. Most other hospitals and Regional Health Authorities (RHAs) do not. Indeed, hospital boards have not seen it as their concern. It has been a classic case of “if we don’t know, we won’t have to deal with the difficult issues that would arise.”

Making hospital and RHA boards accountable for access is coming to be understood as the key to ensuring timely access to care, as the boards are

tal boards, the Ontario approach includes substantive conditions attached to the funding of incremental surgical volumes and MRI hours. It is expected that the conditions will encourage fundamental system redesign of surgical and diagnostic processes. For this to happen, all providers must come to see themselves as functioning within “programs of care,” not as individual entities. A particularly noteworthy example of a program of care is the recently announced pilot project in Alberta to improve access to hip and knee replacement through the creation of a centralized patient assessment and booking process in three health regions.

We can and must do better in meeting the needs of patients for timely and appropriate access to care. Baker and Schwartz’ paper sets out the parameters of system redesign based on results in other jurisdictions. Our

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the only governance point of interaction between management and physicians. That is why many provinces, in particular Saskatchewan and Ontario, are focusing on boards and their accountability for patient access. Boards can fulfill this accountability through insisting on system redesign – comprehensive, sustainable, system redesign that organizes access to care around patients and their relative clinical needs. To assist hospi-

success in meeting the needs of patients will be determined by our collective willingness to embrace substantive change through system redesign.

### About the Author

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