Journal Scan

International Perspectives on Waiting Lists

The Canadian View

Ending Waiting-list Mismanagement: Principles and Practice **S. Lewis et al.**

Waiting for Medical Services in Canada: Lots of Heat, But Little Light **M. Barer et al.**

Morris Barer and colleagues present their reviews of waiting lists for medical services in Canada and report "disturbing chasms" between widely held views and the research evidence.

The authors attribute this gap to confusion over terminology, differences in measure and methods, and a lack of awareness about management approaches. They also contend that frequently offered solutions such as introducing a two-tiered system and allocating additional funding are not supported by evidence.

The authors conclude that Canada needs a better infrastructure of information about waiting lists and their management.

In an accompanying editorial, Steven Lewis and colleagues contend that information and management defects are almost always prematurely diagnosed as financial shortages. They conclude that: "The waiting-list 'nonsystem' in Canada is a classic case of forced decision-making in absence of good management information. There is a surfeit of nonstandardized data and a dearth of usable, policy-oriented information about waiting lists."

Canadian Medical Association Journal
Vol. 162 No. 9
May 2, 2000
www.cma.ca/cmaj/vol-162/issue-9/pr-9.htm

From the UK

Waiting Lists Initiatives Have Not Diminished the Demand for Private Medicine **B. Williams et al.**

The demand for privately funded surgery has remained high despite years of effort to reduce National Health Service (NHS) waiting lists, suggests research from the University of Nottingham.

Williams and colleagues assess the proportion of scheduled admissions to all NHS hospitals and to 215 of the 221 independent hospitals for non-psychiatric and non-maternity care for the financial year 1997-8 in England and Wales which were funded privately, and compared the findings with those of three similar surveys in the previous 20 years.

The results showed that 14.5% of patients had been privately funded, including 13.5% of surgical patients.

These figures have remained constant for the past 20 years. One in 10 private patients had been treated in NHS hospitals, compared with 1% of NHS patients in private facilities, but it is unlikely that all surgery carried out privately would have been done in the NHS, say the authors.

The data show that a higher than average proportion of patients pay for surgery to relieve severe disability and discomfort, such as hip replacement and cataract removal, and to delay the risk of death, such as coronary artery surgery. But there were also a higher than average proportion of procedures for cosmetic surgery, and gender reassignment, considered low priority in the NHS, and of some procedures, such as middle ear drainage with grommets and varicose vein stripping, whose effectiveness is, in some cases, questioned, say the authors.

British Medical Journal
April 1, 2000
No. 7239 Vol. 320
http://bmj.com/cgi/content/full/320/7239/904

Also from the UK

Nurses Could Cost the NHS Less Than GPS for the Same Results
http://bmj.com/cgi/content/full/320/7241/1048

Costs of Nurses Telephone Consultations Out of Hours Outweighed by Savings
http://bmj.com/cgi/content/full/320/7241/1053

Patients as Happy to Be Seen by Nurses as by GPS for Same Day Consultations
http://bmj.com/cgi/content/full/320/7241/1038
http://bmj.com/cgi/content/full/320/7241/1043
British Medical Journal
Vol. 320 No. 7241
April 15, 2000

From the Journal of the American Medical Association

Perspectives on the Plight of Academic Health Centers

A collection of essays on the state of academic health centers in the United States: Pardes on economic measures needed to support teaching hospitals and medical schools; Griner and Danoff on allocation of resources for medical education; Bulger on elements for reenvisioning academic health centers as therapeutic organizations; Saxton and coauthors on strategic planning and organizational initiatives for innovation at one academic health center; and Fein on actions by the leadership of academic health centers that would promote fiscal relief. In an editorial, DeAngelis asserts that to

resolve problems affecting academic health centers, physicians must reclaim from business organizations the ultimate responsibility for patient care, medical education, and research.

Journal of the American Medical Association
Vol. 283 No. 18
May 10, 2000
http://jama.ama-assn.org/issues/v283n18/full/jtw00013.html

In the Journal of Healthcare Management

Strategic Cycling: Shaking complacency in Health Strategic Planning **Jim Begun and and Kathleen B. Heatwole**

As the conditions that affect business and healthcare organizations in the U.S. have become more turbulent and uncertain, strategic planning has decreased in popularity. Strategic planning is criticized for stifling creative responses to the new marketplace and for fostering compartmentalized organizations, adherence to outmoded strategies, tunnel vision in strategy formulation, and overemphasis on planning to the detriment of implementation.

Yet effective strategic planning can be a force for mobilizing all constituents of an organization, creating discipline in pursuit of a goal, broadening an organization's perspective, improving communication among disciplines, and motivating the organization's workforce. It is worthwhile for healthcare organizations to preserve these benefits of strategic planning, while recognizing the many sources of turbulence and uncertainty in the healthcare environment.

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www.ache.org/PUBS/jhm445.html

NEXT ISSUE:
We continue our focus on Cancer Care with "Supportive Care for Cancer Patients" by Dr. Margaret Fitch.