

# Waiting Lists? What Waiting Lists? Not Nursing's Problem

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Canada is experiencing problems with wait times for specific healthcare services. This is not uncommon in countries that have a socialized healthcare system. In Canada, the most egregious problems involve wait times for diagnostic tests, particularly MRIs and surgeries for cataracts, hip or knee replacements and cancer. Recently (June 12, 2005), the Supreme Court found in favour of a patient from Quebec and his physician (*Chaoulli v. Quebec*) who challenged the system because the patient had to wait more than a year to get a hip replaced. Technically, the decision pertains only to the province of Quebec and its healthcare system, but it is seen to have implications for all provinces. Essentially, the Supreme Court declared that waiting an extraordinary length of time to receive necessary services from the public system was contrary to a person's human rights and freedoms as guaranteed in the province's Charter. Therefore, people should be able to purchase insurance to cover these services from a private provider in order to access them within a reasonable period. Until this decision, it was not possible in any Canadian province to have private insurance coverage for services mandated

and paid for by the public system, the rationale being that this restriction gives every citizen equal access to services regardless of ability to pay. Waiting lists are the mechanisms to guarantee equity of access. Individuals who have the ability to pay should not be permitted to “jump the queue.”

This Supreme Court verdict created a huge brouhaha across the country. The decision received support in some quarters as providing a solution to the waiting-list problem, and it was condemned by others as signalling the end of the publicly supported healthcare system. Still others viewed it as a wakeup call to the public system to find a way to reduce waiting times to a safe and reasonable level and to do so quickly, certainly not the several years that the provinces and federal government had given themselves. Nursing as a discipline was silent: silent both about the decision and about its implications for the current health system, and silent on the issue of waiting lists. No nurse was asked by the media for an opinion on the implications of the decision. This is surprising and unacceptable. Unlike medicine (Lewis 2005b), nursing has been an unapologetic advocate of the publicly funded, single-payer system. Where were we, then, in response to this threat? Where were we with our position on waiting lists? What is our position?

By late July and early August, organized nursing did begin to respond. The Registered Nurses Association of Ontario (RNAO) wrote a letter to the premier of Ontario and, through its website, mobilized a write-in campaign in support of the public system. The Canadian Nurses Association issued a statement of support for the public system. However, neither of these organizations took on the waiting list issue per se or offered specific ways that nursing and nurses might contribute to a solution. Yet nurses care for patients who have spent months, frequently in pain, waiting for hip or knee surgery while their functional ability deteriorates. Some of these patients are in much poorer health by the time they get to the OR because of the wait times. Nurses care for cancer patients who, having been diagnosed, must wait weeks for surgery while wondering if the cancer is making irreversible advances. Have we nothing to say about these situations?

Can the waiting-list problem be resolved without nursing's involvement and input? Some of the backlogs seemingly could. Nurses have little to contribute

to reducing MRI waiting lists, but it is hard to imagine that the hip and knee, cataract and cancer surgeries can be reduced without nursing's contribution. But do we know the shape this contribution should take? Is the shortage of nurses contributing to waiting lists? Would the introduction of nurse anaesthetists help solve access problems to surgery? (And, by the way, why does Canada not have nurse anaesthetists when they manage more than 50% of the surgeries in the United States?) Or, given the nursing shortage, would this be substituting one short-in-supply professional for another? Has nursing analyzed the effect that the substitution of nurses for physicians or other providers would have in either reducing or exacerbating the waiting-list problem, and the numbers involved in either creating or resolving these problems?

During the last big nursing shortage in the 1990s, staff nurses at the Hospital for Sick Children in Toronto pointed out that some surgical units could be closed on weekends (thus not having to be staffed) if elective surgeries were booked on the basis of the average lengths of post-surgical stays of patients – e.g., surgeries requiring four-day post-surgical stays should be done on Mondays, three-day stays on Tuesdays and so on. Linda O'Brien-Pallas of the Faculty of Nursing at the University of Toronto, working with colleagues from the Department of Mechanical and Industrial Engineering, developed a computer-assisted model that showed how many bed days could be saved if the surgical schedule were developed on the basis of nursing care required as measured by lengths of stay (Blake et al. 1995). This model was not implemented because of several factors, including the fact that it would have totally disrupted the surgeons' OR schedules and, thus, their entire working week. This is not a trivial disruption, and it demonstrates that interdisciplinary participation is required to solve the systems' problems. On the other hand, it showed that taking a systems approach can provide reasonable solutions to some nursing staffing problems.

I think the *Chaoulli* decision was an important contribution to the evolution of Canada's healthcare system. Although the Supreme Court justices erred in several aspects of their understanding of the system (Lewis 2005a), they reflected the view of many Canadians: it is unreasonable to wait for months or years for medical procedures that profoundly influence your independence and your overall health status so that you are at higher risk

for poor outcomes because of the wait. Waiting-list management is a complex issue not solved solely by increasing resources across the board (Baker and Schwartz 2005), but more resources may have a role to play. What does this mean in terms of nurses?

Along with all my nursing colleagues, I reject a parallel private system as any part of the solution, let alone the preferred solution; however, nursing cannot get by simply by repeating in unison the same mantra: “We support the public system. We reject a private system.” We have to do our homework and examine how a variety of changes could contribute to solutions to waiting lists as a way of demonstrating concrete support for the public system. If an increased number of nurses would contribute to shortening waiting lists, what’s the ballpark figure for these increased numbers? In what areas should they be deployed? If we are to increase the number of nurses in specialized roles (nurse practitioners, nurse anaesthetists), by how much must we increase nursing enrolments to accommodate these roles and still have a sufficient number of nurses to support other aspects of the system? An analysis is needed of whether increased opportunities for nurses to enter these specialized roles would increase recruitment into nursing.

Nursing as a discipline in Canada does not assert itself as a knowledgeable and opinionated policy source. When Longwoods, the publishing house that produces this journal, puts together a panel to respond to health policy issues and disputes – e.g., Longwoods e-letters – a nurse or two should be included on that panel. But we have to earn our place at the table. A good start would be for a nurse or nurses to step up to the plate with a pithy and solid analysis of the waiting-list issue from a nursing perspective, with recommendations for nursing’s contribution to ameliorating it. Any takers?

## **References**

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