The continuing challenge of surgical access

In this issue of *CJS*, Wright and colleagues[1] describe a refreshing strategy to develop standardized, comprehensive access targets for timely surgical care. This provides a timely opportunity to reflect on access to surgical care in Canada. Over a decade has elapsed since priorities for waiting lists were defined by the steering committee of the Western Canada Waiting List Project.[2] Subsequent commitments to decrease wait times have targeted adult health care in areas for cataract surgery, diagnostic imaging, cardiac care, joint arthroplasty and cancer surgery. Although these commitments have limited suffering and financial hardship, the devotion of increased resources to targeted areas has limited resources available for others.

To arrive at pediatric wait time targets, Wright and colleagues captured wait time targets by diagnosis rather than by procedure, allowing a more sensible matching of priority scores that should rightfully drive the need for access. This is a far more objective approach than simply building lists of patients requiring named surgical procedures. Moreover, the development of targets for all procedures allows for monitoring services delivered to determine whether targeting certain procedures has a detrimental effect on access for others.

Provision of access targets is one of several approaches needed to manage wait times. Surgeons need to be aware of these approaches as they impact surgical practice. Access targets that reflect diagnostic codes rather than procedure codes will promote a new language to justify access to operating rooms. Effective disease and referral management systems will be used to screen patients and improve appropriate referral to the surgeon. Some of these models have been developed to refer patients requiring joint arthroplasty, foot and ankle, bariatric or pediatric surgery. Wait time management systems require surgeons to agree on common definitions of wait times on a provincial and pan-Canadian basis. For example, definitions of wait times must be consistent. The definition used by Wright and colleagues is the date of the decision to operate to the time that surgery is provided. From a patient perspective, this is a transparent definition; however, many jurisdictions struggle with it because waiting list data cannot be objective unless all information is identified in the hospital booking office rather than sequestered in the offices of individual surgeons. Electronic booking is urgently needed to make this wait time seamless. The data must also be "cleaned up" on a regular basis to remove patients who received their surgeries.

With respect to sharing of data, a surgical patient registry is essential. Several provinces have these registries, allowing red flags to be placed on categories of patients whose waits have exceeded targets. This information allows chiefs-of-service to address shortfalls. As usual, the availability of resources is a major limitation to access. Recent news headlines in Canada have identified mismatches between resources and the supply of foot and ankle surgeons.[3] These problems have been intensified by challenges to fund tests, imaging, beds and rehabilitation, and fewer senior surgeons are able to undertake normal retirement plans. Furthermore, a workforce of fatigued and retiring nurses is anticipated. Perhaps a wider range of skills would provide new surgeons with a buffer, helping them to work within a resource-constrained system. The idea that "you get to know so much about 1 thing that pretty soon you know little about everything" haunts surgeons who limit their skill sets. A method of resource allocation based on surgeon-defined wait time targets can help assure transparency. Finally, the use of infrastructure must be targeted in effective and creative ways. Regional surgical planning will continue to evolve. Regional programs will harness resources to position service delivery where it is most effectively provided. Models of operating room access that allow higher volumes of patients to be treated have already been characterized. Patient-focused funding models are being used to financially reward hospitals, which then have incentives to catch up to backlogs of care for patients who have waited too long.

Surgeons need to be aware of evolving access targets and strategies to increase access to pediatric or adult surgical care. The development of standardized comprehensive models across Canadian jurisdictions will improve access in the short term and serve as a basis for improved outcomes in the long term.

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References

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