



Waiting for medical care: Is it who you know that counts?

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Medical care should be different. Queuing for a bus or a theatre on a first come, first served basis seems entirely reasonable, but most Canadians would agree that medical services should be allocated on the basis of need, such that the worst off are at the front of the queue. Who you know should be, quite simply, irrelevant in the allocation of medical care. But how do these moral precepts play out in practice? In this issue¹ (page 813) Dr. David A. Alter and colleagues expand our appreciation of the complexity of such equity concerns.

The question at issue is deceptively simple: Is the allocation of Canadian health care fair? This is, of course, quite different from the question of whether it is clinically effective. One might initially approach this inquiry at a general level by determining whether there are obvious barriers to the receipt of services. By creating a system built on the principle of universal access to comprehensive medical services, Canada would appear to have created a commendably level playing field.

Three decades of research generally confirm this impression. Studies of medicare in the 1970s suggested that the burden of medical costs had become more equitably distributed through a marked shift in utilization from people with higher incomes to those with lower incomes.²⁻⁵ Two important studies in the following decade used data from the Canada Health Survey to show that the use of physician services⁶ and of hospitals⁷ was determined by medical need and sociodemographic characteristics rather than by income. These conclusions have been confirmed in the 1990s by 2 studies that used General Social Survey data to document the fact that variation in self-assessed need is an important factor in variations in physician⁸ and hospital utilization,⁹ whereas income is not. Finally, if any doubt remains about the equity of Canadian health care, a scholarly glance across the border reveals that economically disadvantaged people in Canada enjoy far better access to hospitals,¹⁰ physicians¹¹ and mental health services¹² than do their counterparts in the United States.

At a systemic level, then, Canadian health care seems resolutely fair. Unfortunately, when we scrutinize the provision of specific medical services, small cracks begin to appear in this equitable edifice. The study by Alter and colleagues¹ is a case in point. On a clinical level, the allocation

of access to angiography, though informal, produced results that were in moderate agreement with what would have been expected from the application of an explicit urgency rating scale. However, almost 10% of the variation in patient waiting times was found to be explained not by clinical factors but by the hospital affiliation of the referring physician. From the patient's point of view, "who you know" turns out to be disconcertingly important.

It is reassuring to find, as has been reported elsewhere,^{13,14} that triage based on clinical judgement can achieve results broadly similar to those of more formal guidelines. But, to paraphrase Lord Acton's dictum, justice must not only be done but must also be *seen* to be done. An objective urgency rating system, such as that used to allocate coronary artery bypass graft surgery in Ontario, seems best calculated both to minimize adverse clinical outcomes¹⁵ and to provide transparent evidence of allocative equity. Both patients and referring physicians can quickly discover via the Internet the principles used by the Cardiac Care Network to prioritize patients and the current waiting times at different surgical centres.

That systematic triage to match receipt of service to patient urgency is — despite our broad equity achievements — still necessary is suggested by fragmentary evidence in the literature on queuing. In an earlier survey by Alter and colleagues¹⁶ a significant proportion of physicians and hospital executives reported that they had arranged accelerated access to services for personal contacts or prominent people.¹⁶ This finding suggests a possible socioeconomic triage. Although researchers in Manitoba were unable to link surgical waiting times to socioeconomic status,¹⁷ Paszat and associates¹⁸ demonstrated in an ecological study that residence in an area where the median annual household income was less than \$20 000 was associated with a significantly lower likelihood of receiving radiotherapy within 1 year of diagnosis of breast cancer compared with residence in an area where the median annual household income was more than \$50 000.¹⁸ As well, Naylor and associates reported that employment status of patients may influence prioritization for cardiac surgery,¹⁹ a finding also reported in Ireland.²⁰ Interestingly, the Irish investigators reported elsewhere that cardiac surgery patients perceive the likelihood of return to gainful employment as a legitimate criterion on which to base allocative decisions.²¹



How widespread is the use of such nonclinical factors in allocating waiting times for medical services in Canada? The answer is simply that we have no way of knowing. As a recent report for Health Canada documented,²² the decentralized, ad hoc fashion in which waiting lists are created and used in Canada makes informed generalizations impossible. However, despite the reassuring findings on informal clinical triage, this study by Alter and colleagues should serve as both a timely warning that allocative equity can not be taken for granted in Canadian health care and that the broad issue of waiting for medical services demands continued scholarly scrutiny.

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