Commentary

Québec's Emergency Room Overcrowding and Long Wait Times: Don't Apply "Band-Aids", Treat the Underlying Disease!

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Introduction

A report by Québec Health and Welfare commissioner Robert Salois, released on June 2, 2016, stated the obvious: our province has "the worst emergency [department] (ED) wait times in the Western world" (1). Our EDs are overcrowded, causing long wait times (the time spent in the ED before being seen by a physician). Productivity is diminished and wages are lost while patients are waiting in the ED, posing a substantial burden to the economy. Tragically, increased ED wait times also affect the quality of patient care, and on occasion contribute to irreparable health damage or even premature death.

Attempts have been made to address the wait time in the ED by reshuffling the ED teams (for example, by creation of fast track, ambulatory and acute sections of EDs). In this essay I will argue that the current problem with Québec EDs cannot be solved without major restructuring of the health care system as a whole. Specifically, refocusing the provincial healthcare

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system to community-based patient care, in place of the current hospital-focused acute care system, is the key solution to the ED wait time problem. Community-based patient care will allow for better access to medical services in Québec, with ambulatory medical care available for less urgent health conditions. This will also improve the management of chronic disease. Fewer disease flare-ups will mean fewer visits to the ED. These changes will markedly reduce ED overcrowding and decrease wait times – far beyond what can be achieved by reshuffling of ER teams.

Overcrowded EDs is a decades-long problem in Québec

The problem of long wait times in EDs has existed for decades in Québec. After introduction of the Canada's Hospital Insurance and Diagnostic Services Act in 1957, which warranted free medical care in hospitals and outpatient clinics, hospitals have been perceived as the primary point of medical care (2). In Québec, massive investments into hospitals' emergency and outpatient services were made at the expense of services provided outside of the hospitals.

Deinstitutionalization of psychiatric care in 1970s, and lack of investment into ambulatory elderly and end-of-life care aggravated things further. Hospitals assumed responsibilities for psychiatric, elderly, and palliative care patients. This was followed by massive cuts of health-care related expenses in the early 1990s. All these changes greatly contributed to ED overcrowding (3). Not surprisingly, 35% percent of patients now have to wait for five or more hours in the ED (4).

ED overcrowding compromises the quality of patient care by delaying treatment and increasing the risk of complications from acute medical issues (5). Several disturbing cases of patients dying while waiting in the ED have been previously reported. In 2010, André Desjardins, a 64-year old man with diabetes, died in a wheelchair in the waiting room of the ED of the Maisonneuve-Rosemont Hospital in Montreal. Mr. Desjardins waited seven hours for medical care that never came (6). On November 16, 2010, Thérèse de Repentigny, 78 years old, died after waiting for six hours in the ED (7). Another woman, Françoise Parent, 67 years old, died of cardiac arrest at Pierre-Boucher Hospital in Longueuil in July 2013. Ms. Parent waited for thirteen hours in the ER without having been seen by a physician (8).

ED overcrowding causes frustration to both patients and medical personnel (9). Furthermore, as previously mentioned, ED overcrowding poses a serious economic burden (1). It is estimated that between 2015 and 2016, Québec residents spent 13 million hours waiting in EDs. Based on average salary in our province, this amounts to 300 million dollars in lost wages (1). Productivity losses associated with the time spent waiting in ERs are also substantial. As stated by Robert Salois, the Québec Health and Welfare commissioner, overcrowding and long wait times in ED "have become a chronic, socially unacceptable problem that has gone on far too long" (1).

Are ED overcrowding and long wait times inevitable? My personal life experience indicates the contrary. Before coming to Canada, my family and I lived in Germany. Unlike in Montreal, it was easy to find a family physician. From time to time, we experienced health-related issues, and the family physician attended to most of those problems. The few times when ED visits were truly needed, wait times were short, mostly not exceeding 20 minutes.

These observations are supported by statistical reports. As mentioned before, 35% of people reported having waited in Québec EDs for five or more hours during their last visit. In comparison 0% of the Dutch, and only 5% of Germans and Americans reported similarly long wait times in the ED (1). Even neighbouring Ontario reports only 15% of people who experienced as long a wait in the ED. Reflecting this, Robert Salois underscores that "long waits in emergencies are not an inevitability" and that "most countries in the world do not have this problem" (1).

Emphasizing community-based primary care

Various attempts to address the problem of ED overcrowding and long wait times have been undertaken. For examples, wait times have been somewhat shortened through improved management. More efficient EDs, such as the one at the Jewish General Hospital, cut the wait time by improving triage to focus on true emergencies. Less urgent cases are re-directed to outpatient health clinics (10). Reshuffling the ER team can further shorten the wait time. Thus, the Jewish General Hospital added a physician to the ED triage team. This has helped to more efficiently identify and redirect non-emergency cases, thereby diminishing ED overcrowding and shortening wait times (11). One could argue that the aforementioned

solutions will yield some improvements, but do not address the root of the problem.

It is not only poorly organized hospitals that has led to such overcrowded EDs in Québec. It is estimated that 50-60% of visits to EDs are not urgent and could easily be attended to in an outpatient care setting(1, 12). Unfortunately, in Québec nearly two million people do not have a family physician (12). These people often go to the ER for routine care. Giving these people a readily access to primary care will decrease ER overcrowding.

This accomplishment will also save substantial costs. Indeed, an ER visit costs at least four times more than a visit to a family physician (13). Moreover, patients who regularly see a family physician eventually cost less to the health care system. These patients have better health and spend less time in hospitals (12).

Rather than emphasize the current curative- and hospital-based model, the focus should be on a community-based primary care system. Better access to primary care improves health outcomes, increases patient and physician satisfaction, and reduces the number of emergency visits (9, 14). The benefits of such a restructuring have been noted by multiple people including David Levine, the former Junior Québec Health Minister (14).

Until there are sufficient primary care resources in our province, hospital ERs will remain the crucial point of care (15). It is encouraging that the problem with insufficient access to primary care has been recognized. Promotion of primary care practice and local health networks has been an important part of the current Québec government's ongoing reform of health and social services (16).

One of the specific objectives of this reform is a placement of family physicians within a multidisciplinary team at the centre of this community-based care model. Essential elements of the health care model have been identified by The Clair Commission in 2000 (17). These elements are called "Medical Homes" or "Groupes de médecine de famille" (GMF) in our province. These "Medical Homes" are teams of health professionals (physician assistants, nurses and other caregivers) who work with family physicians to provide a wide range of medical and health care services tailored to patients (18). The evidence points out that introduction of "Medical Homes" improves the accessibility of care, increases the relative proportion of preventive care (19), and improves health outcomes (20).

Despite increased recognition of the importance of the primary care-based model, the current Québec model remains heavily focused on the hospital-centered system (15). Other changes are being implemented, but not as fast as they should be.

Conclusion

Thousands of Quebecers spend long hours in ERs waiting to be seen by a physician (1). François Paradis, leader of Coalition Avenir and Québec health care critic, sarcastically comments that it is now the "time to change the motto on our licence plates to say 'J'attends' (I'm waiting)". Ultimately a change from the current hospital-focused acute care to a community-based patient care is needed. Under this new model, family physicians and associated clinical teams will provide a full range of medical care, including disease prevention and care for chronic diseases. This will decrease the number of visits to ER for routine care and lower the incidence of acute disease flare-ups.
I hope that my daughter will be able to take her children to one of the outpatient clinics for routine or even emergency visits rather than wait at the ED.
In the meantime, j'attends.

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