Editorial

Emergency departments and waiting lists

For national health systems that offer universal health care without financial contributions, addressing the balance between supply and demand is done by limiting access to resources, in other words, by using waiting lists instead of price to ration services and delay certain practices. Basically, this resource management tool has been used in the majority of high cost diagnostic procedures and in many non urgent surgical operations (NUSO)[1].

However, during the last two decades in over half the OECD countries, especially those which operate a mixed model of funding combining public and private contributions (supplementary private payments), the usual delays for NUSO have been accompanied by excessive waiting times for other medical services. These services are often neither surgical nor therapeutic and include simple consultations with specialists for example[2].

The disparity between supply and demand is an issue that is worrying many people, including health professionals and those in charge of health policies. Waiting lists (WL) potentially damage the quality of the health system and generate a constant stream of complaints from the public who are negatively affected by them. However, the shortfall does not seem to be related to problems with the supply but to limited funded demand[3].

This ongoing phenomenon, which faces international criticism as national health systems, welfare, society and the state gained has strength, and has forced important and relevant organisations to carry out in-depth social, medical and economic research. The OECD project[2,4,5] is essentially based on objectives that are focussed on evaluating the initiatives implemented by the administration, to reduce delays in the twelve member countries. It also analyses the causes, similarities and differences between the various health systems.

It is necessary to point out that, although certain countries in the OECD are experiencing "serious delays", they cannot always be attributed to the same factors. There is an important health issue in these twelve countries (Australia, Canada, Denmark, Finland, Ireland, Italy, New Zealand, Norway, Holland, United Kingdom, Sweden and, of course, Spain) which seems to be linked to seriously limited public funding[2,5].

There is clear negative correlation between delayed action and resource capacity, which is usually calculated by the number of beds or working professionals. In the aforementioned countries the medical supply is greater. According to econometric estimates, which include a multivariate analysis, a marginal increase of 0.1 working doctors and specialists per thousand people would mean an average reduction in waiting times of 8.3 and 6.4 days, respectively. Furthermore, an increase of 100 dollars per person in the national health system treasury would reduce waiting times by an average of 6.6 days[2,5].

By comparing OECD countries, especially those with little or no waiting time, we can see how the supply of hospital beds for short stay patients is closely linked to reduced waiting lists[2,5]. Moreover, there is also a link between waiting lists and specialists who are paid per procedure compared with those who receive a salary. It is clear that direct payment increases productivity in certain models, which confirms that hospital funding linked to activity could also contribute to a reduction in waiting times[2,5,6].

Although the literature suggests that there is little evidence to support the fact that waiting poses clinical risks for patients, especially in cases of elective surgery[6], in actual fact the number of conditions that cause discomfort and incapacity, rather than pain and a general inability to function normally, is very high. These problems can become more complicated and serious and occasionally can even be fatal. Therefore, it is more cost effective to keep waiting lists short given that the adverse financial consequences of this are insignificant compared to the financial savings made by the medical centres. If the price is zero the demand will be infinite[7].

Several different intervention models to limit the effects of waiting lists have been considered: increase productivity in the public sector by funding specific services, introducing direct payments for these services, revising specialists' contracts, improving the performance of surgeries and using private resources[2,5]. Howevers none of them have clearly reached their objective. The problem is undoubtedly an economic one and the solution involves a cash injection and new ways of managing staff.

However, the definitive solution which implies an increase in funding, even in high income areas[8], is not easy to implement. Society assumes that the problem lies in accessibility; the opinion that "perceived need" can turn into "expressed need" and turn urgent demands on the health system. The conceptualisation of a clinical process considered urgent is both complex and diffi-

cult because it is acceptable from a purely social perspective but not from a scientific one. Furthermore, if technological advances are progressively facilitating positive results for sophisticated medical procedures, reducing risks and rapidly improving quality of life, then the need and the demand for health will be within the reach of more people.

Only the individual's belief that public resources and the associated funding are not being used correctly could alter the existing dynamic. However, unfortunately, we are still very far from reaching the level of social culture required for this personal response. Moreover, since financial contribution mechanisms clearly do not have the effect of dissuading or fund raising and can have a negative and worrying impact on the most disadvantaged and sick people, using the emergency route to gain access to the national health system has become routine procedure. In other words, it has become official.

It is becoming increasingly common to receive complaints or suggestions from professionals in the emergency department about the lack of resources, the incredibly high number of people who should not be using hospitals as a way to gain access to services and the limited use of primary health care. There are also thousands of other objections against a dynamic that has become popular in society. In my opinion, the problem lies elsewhere. It lies in transforming the social demand, which has been inadequately dealt with up until now, through politics. This course of action should be accepted as soon as possible in order to implement the necessary tools and mechanisms which would allow a sustainable balance.

Emergency medicine is not just a specialisation, and this is something I have been saying for years now, it has now become a subsystem of the health care model. It is a set of extraordinarily complex resources and services which correspond to a specific stage in the patient's condition or incapacity. The demand to use them, which is increasing, only serves to confirm society's perception and need. And if that is not the case, only time will tell…

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