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Final Report of The Federal Advisor on Wait Times

June 2006



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Brian D. Postl, MD
Federal Advisor on Wait Times

June, 2006

**To: The Right Honourable Stephen Harper
The Honourable Tony Clement**

In July 2005 I was invited to assume the role of Federal Advisor on Wait Times. I was asked to inquire into the factors contributing to long wait times and to discuss with provinces, territories and stakeholders efforts that could contribute to more timely access to health care services. The federal government at that time sought recommendations and advice, respectful of jurisdictions and powers in Canada, which would ensure the reduction of wait times for health care services.

Specifically my mandate was to:

- advance further action to achieve meaningful reductions in wait times;
- identify and continue to develop consensus on establishing comparative indicators and evidence-based benchmarks;
- assess knowledge gaps and find ways to address them; and
- encourage the adoption of methods and tools to better manage wait times.

I am happy to report to you that I have enjoyed the cooperation of many jurisdictions, institutions and individuals who share in the objective of making timely access to health care a hallmark of Canada's health care systems.

In December of 2005 Federal, Provincial and Territorial Ministers of Health achieved the first major commitment of the 2004 *"10-Year Action Plan to Strengthen Health Care"*. Ten evidence-based benchmarks for timely care in five areas defined by the First Ministers were announced in Toronto, Ontario. These ten benchmarks established a high standard with respect to clinical evidence and for collaboration amongst federal, provincial and territorial jurisdictions. They have incited the health care system to action in these clinical areas and have established high expectations on the part of the public, professionals and your political colleagues for the health care system's achievement.

While the declaration of evidence-based benchmarks is an important milestone in the ongoing effort to reduce wait times, benchmarks alone will not solve the problem of timely access to the health care system. Many factors combine to create the long waits that Canadians sometimes experience. It is the analysis and remediation of these factors that will help to ensure that our achievements in establishing benchmarks show lasting benefits to Canadians. I believe that the consultations that I have undertaken have illuminated many areas to which we can now turn our attention, with the assurance that collective effort on a continuing basis can improve the health care system's efficiency, effectiveness and timeliness.

It is my pleasure to document these findings for your consideration and for that of the public, our provincial and professional colleagues. It is my hope that my observations and recommendations will

permit federal, provincial and territorial governments to engage in additional forward-thinking collaborations and to achieve the kind of health care system that succeeds by making the patient and the patient's needs the focus for our decisions regarding system change. This report is written not only to create a public record of my findings but also to provide an inventory of tools, processes and initiatives that could be employed by individual provinces, territories and governments collaboratively to transform Canada's health care system.

Where my recommendations have funding implications estimates provided are notional and subject to further discussion and negotiation between federal, provincial and territorial governments.

Your government has committed itself to the creation of patient wait time guarantees and will undoubtedly discuss with provincial governments the means to achieve these. I believe that the recommendations put forward here are critical to building the kind of health care system that make the fulfillment of patient wait time guarantees possible.

I have been honoured to have the responsibility of this mandate and I am pleased to submit for your consideration this Final Report.

Respectfully submitted,

Brian Postl, M.D.

Acknowledgements

During the nine months of my appointment as Federal Advisor on Wait Times I have enjoyed the cooperation of a wide array of organizations and individuals across Canada. To all of them I owe a debt of gratitude for their contributions to my understanding of the issues surrounding wait times and the analysis and recommendations that are found in this document.

In particular I would like to express my sincere gratitude to the members of my Advisory Committee and the federal, provincial and territorial Deputy Ministers of Health who freely and generously made time available. A complete listing of all contributors to this process can be found in Appendix G of this report.

I was ably assisted by staff seconded from The Winnipeg Regional Health Authority: Ms. Kim Morrison, Intergovernmental Advisor; Ms. Heidi Graham, Communications Advisor, and Ms. Jolene Chester, Executive Assistant.

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2. Canada Health Infoway: Addressing Wait Times with Information Technology
3. National Child and Youth Health Coalition (NCYHC): “National Paediatric Surgical Wait Times Strategy: Access Targets”
4. Pan Canadian Health Human Resource Strategy
5. Women and Health Care Reform Group: Gender Based Analysis and Wait Times Report: New Questions, New Knowledge

Executive Summary

Recently there has been increasing attention paid to elements of performance in Canada's health care systems from the perspectives of sustainability, efficiency and timeliness. Wait times for some surgical and medical procedures have increased and emergency rooms are seen to be experiencing heavy patient loads with long wait times. New technologies and new drugs bring with them higher expectations and higher costs.

Federal, provincial and territorial governments are engaged continuously in the challenging task of finding solutions to these problems. First Ministers' Meetings (FMM) have devoted particular attention to health system challenges that are intrinsic in the national objective to provide comprehensive care that is accessible to all Canadians.

The issue of wait times has been increasingly a high priority for Canadians and therefore prominent in media reports. Following the 2004 First Ministers' meeting a \$5.5 billion fund was established to assist provincial efforts to reduce wait times. In December 2005 ten wait time benchmarks were established in five priority areas: cancer, cardiac, diagnostic imaging, joint replacement and sight restoration.

However important the issue of wait times might be, dealing with wait times in isolation of health care systems will have limited benefit. Wait times are a symptom of a larger problem. In order to create a more efficient and effective health care system, Canadians need to support a transformation that puts patients at the centre of the system. There are several elements that require attention in this transformation, all necessary but not individually sufficient to create change. I am recommending that this transformation be advanced by immediate action in the following areas:

- ongoing research to support benchmarking and operational improvements;
- adoption of modern management practices and innovations in health systems;
- accelerated implementation of information technology (IT) solutions;
- cultural change amongst health professions;
- development of regional surge capacity; and
- public education to support system transformation.

It is my view that by addressing these key areas patients will be better served, wait times will be reduced and health care systems will become increasingly responsive to the needs of the patient.

Each of these areas is addressed in this final report. I have attempted to provide sufficient background and/or explanation for each of these elements of transformation. It has not been possible to include all of the ideas and arguments for change, nor descriptions of all the innovations that are underway on a large or small scale. In every provincial jurisdiction there are clinicians and managers who are experimenting with innovative ideas and efficiency-seeking practices, whose work is challenging existing practices. We need to harness the initiative and talent that exists in our midst and encourage its further development.

I have identified six areas for recommendations:

Benchmarks, Indicators and Ongoing Research

The 2004 First Ministers' *10-Year Action Plan to Strengthen Health Care*¹ committed provinces and territories to the process of establishing wait time benchmarks for the five priority areas noted above. Evidence-based benchmarks were announced on December 12, 2005 and the provinces and territories are now in the process of implementing changes to achieve these benchmarks by December 2007. First Ministers also committed to establish comparable indicators of access to health care professionals, diagnostic procedures and medical treatments. Provincial and territorial governments have indicated that as of March 30, 2006 comparable indicators to measure progress against the benchmarks have been developed and approved. Continued research is essential. Our efforts to date make the best use of available evidence but as work progresses, we will need more comprehensive knowledge and more conclusive evidence.

I recommend:

- 1. That the Canadian Institutes of Health Research (CIHR) undertake research to:**
 - **evaluate the effect of the benchmarks established through the FPT process;**
 - **broaden the scope of benchmark research to include costing and appropriateness criteria; and**
 - **identify areas in which additional benchmarking is required or desirable to improve patient outcomes.**
- 2. That multidisciplinary, collaborative panels (including researchers, clinicians and government representatives) be established to review evidence and recommend additional benchmarks to FPT governments;**
- 3. That CIHR develop additional capacity through existing health policy institutions across Canada to enable them to study best business and industrial practices to support wait time reductions.**

Management and Innovation

There are many practices that can be adapted from the experiences of business and industry to increase the efficiency and effectiveness of Canada's health care system. In many respects our health care systems have fallen behind other human service sectors in adopting modern management practices and the innovations that guarantee that services are provided at a high level of quality, consistency and timeliness. Our system can adapt high standards of performance from wherever they exist, using leaders to influence change and training programs to bring the workforce up to new performance standards.

¹ 2004 FMM 10-Year Action Plan to Strengthen Health Care is available on the Health Canada website found at: http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html

I recommend:

- 4. A national network of wait time champions (one per province) be established to lead the development and promulgation of best practices throughout provincial health systems;**
- 5. As an extension of the foregoing recommendation, that provincial capacity for wait time coordination/navigation in health regions and major institutions be established;**
- 6. That the Canadian Health Services Research Foundation implement a continuing, multidisciplinary educational program for health care professionals, for the purpose of developing wait list management leadership and skills and for a period of time that equips existing health care professionals to adopt best practices;**
- 7. That provinces and territories adopt best practices for wait times including:**
 - the use of single common waiting lists;**
 - an approach that permits patients to be referred to a speciality service that prioritizes the patient by acuity and offers the first available slot for intervention;**
 - the use of queuing theories to alter current processes;**
 - innovative case management;**
 - team based care;**
 - appropriateness; and**
 - pre-habilitation programs to ensure fitness for surgery.**

Information Technology (IT)

The rapid acceleration of efforts to develop information management and technology will play an important role in supporting innovation. Its most important role will be to ensure that the right information is in the right hands at the right time. IT initiatives are costly to implement, but the resulting efficiencies and rebuilding of public confidence will mitigate the expense. Many features of information technology require development, including:

- a system-wide electronic health record for all Canadians that will ensure that each physician, specialist, nurse or other appropriate health care professional has current and accurate information on which to base a diagnosis or treatment decision;**
- electronic patient registries that will allow a fluent flow of patients through the system;**
- digitalization of diagnostic images that provides the opportunity for faster access to the images and elimination of duplicated diagnostic testing, resulting in faster diagnosis;**
- tele-health to provide increased access to patients who may be in remote areas or have mobility challenges, as well as providing new opportunities for professionals to provide team-based care.**

Each of these technological advances increase the accuracy of and access to information for patients and professionals alike. Patients can expect to receive better care in a more timely manner as a result.

I recommend:

- 8. That the federal, provincial and territorial governments accelerate the pace of pan-Canadian health information technology through Canada Health Infoway;**
- 9. That Canada Health Infoway:**
 - **Develop wait time tools as proposed;**
 - **Continue the development of the Electronic Health Record with a plan and timeline supported by FPT governments;**
- 10. That the development of IT health information systems in Canada be accompanied by public education to assure Canadians that privacy of information is secured.**

Professional Roles and Responsibilities

The issue of wait times is a systemic problem that requires a systemic solution. Specific measures will be required to advance solutions. Physicians have played a large and important role in defining needs and solutions for wait list management in our systems. The continuous role of physicians is essential for any changes in how we manage wait list issues. In ensuring their involvement a cultural shift is needed from individual contributions to system involvement and problem solving.

Physicians represent only one group of professionals involved in patient care. Other groups play important roles in the continuum of modern health care. These professionals organize and deliver care across facilities, in and out of acute care, in the home, in private offices and in community settings. The roles that physicians play as “gatekeepers” of the system, as leaders and as independent professionals means that they are key to system change. We need their support and involvement but also their commitment to full participation. Their ability to adopt the measures of change and the culture of change will serve as an important guide for other health care professions.

I recommend:

- 11. That FPT governments develop a broad base for receiving advice from medical communities with respect to change in the health system and long term planning. The Canadian Medical Forum can be asked to assume this role nationally, with provinces developing similar capacities locally to achieve balanced influence when medical input are deemed important;**
- 12. That provincial Colleges of Physicians and Surgeons establish professional and ethical standards and the means to monitor professional practice with respect to physician management of wait times in provincial health care systems. The Federation of Regulatory Authorities of Canada should coordinate this effort;**

- 13. That Faculties of Medicine of Canadian universities develop curricula that supports changing health care systems and changing expectations regarding the competencies that physicians will require to participate in these systems led by The Association of Medical Faculties of Canada; and**
- 14. That FPT work on Health Human Resources initiatives focus on re-defining professional clinical roles to enable health care professionals to work at their full potential and to offer innovations in health care, which are economical and sustainable.**

Additional Issues

Several issues emerged early in my consultations that were not included in my mandate as Federal Advisor on Wait times but were sufficiently important that I want to comment on each. These issues are: wait time benchmarks for children, surge capacity, health human resources, “Cinderella” diseases and gender-based analysis.

Benchmarks specifically directed to interventions for children were not included in the decisions of the First Ministers in 2004. Yet the timing of interventions may be particularly critical for children for two reasons. First, there may exist in the normal development of a child a limited window of opportunity in which an intervention can have the most beneficial effect. Second, the delay of an intervention can cause normal growth and development to be impeded. We need to ensure that wait times for children are given due consideration.

Surge capacity is additional care capacity that is available when and if required. We are most familiar with the idea of surge capacity in the context of public health, such as in the circumstance of epidemics or pandemics. Severe Acute Respiratory Syndrome (SARS) gave health care systems reason to consider the need for planned capacity to be used in times of system stress. Surge capacity is discussed in this report to encourage collaboration on the need for specific regional and national capacities to address wait times and to enable systems to accommodate stress or overload within Canada’s borders.

The issue of health human resources (HHR) has been high profile both before and during the discussion of wait times. Shortages of family physicians, anaesthesiologists, nurses or other specialists and health care professionals have added to the stresses and pressures on the health care system. Shortages can add to the problem of wait times and prevent the implementation of solutions. All levels of government are working together on a pan-Canadian strategy to recruit and retain additional health care professionals. At the same time there is an effort underway to work toward innovative use of health human resources by maximizing the use of skills that various health professionals have acquired and by promoting team-based care.

There has been substantial progress over the last few years in understanding the effect of gender in the analysis of health conditions and solutions. Gender-based analysis (GBA) provides a different set of questions about decision and policies in the practice of health care. GBA could study how men and women are differentially affected by waiting for care and could also be applied to additional questions that are associated with the choice of conditions, the effect of benchmarking and the outcomes of benchmarked care compared to care that is delayed further. GBA recognizes that there are significant

differences in access and use of health services that are affected by gender and takes this into consideration when providing advice to policy-makers.

I recommend:

- 15. That provincial and territorial governments give consideration to the access targets developed by the National Youth and Child Health Coalition and consult as required with clinical leaders in children's health care, in order to consider their implementation. Further, that the conditions affecting children be included alongside adult-related conditions at the outset of future benchmarking processes to ensure that children receive equitable attention to their time-sensitive needs;**
- 16. That FPT governments mandate an expert group to investigate the need and potential for surge capacity through the development of regional centres of excellence; and**
- 17. That ongoing research related to wait times adopt a broad approach to gender-based analysis in order to ensure that the issues of gender are considered thoroughly.**

Public Education

The growing perception that long wait times are pervasive and that little can or is being done to improve them is eroding Canadians' confidence in the system's future. As we move forward with efforts to address wait times and implement system transformation initiatives, the Canadian public must not only understand why change is necessary but be fully informed of changes as they occur.

I recommend:

- 18. That the public be continually informed and updated of changes taking place in the Canadian health care system;**
- 19. That a three-year public education campaign on wait times be initiated as a collaborative effort between federal, provincial and territorial governments;**
- 20. That a comprehensive, multi-dimensional public education effort with the capacity to leverage support from other partnering organizations be undertaken.**

There are, of course, always financial implications associated with recommendations. Throughout the course of this work various individuals and organizations were asked to estimate the costs of undertaking the research and initiatives that are the subject of these recommendations. These estimates are included in chart form in Appendix C. They represent notional estimates and have not been subjected to thorough analysis or examination. These estimates should not be regarded as final. The ultimate cost of programs and services is normally affected by negotiation, pre-existing agreements and the capacity of partners to produce intended results.

Additional considerations

It may appear to some that there are obvious omissions in this report. I want to address two of them here so that you can be assured that while these issues were not formally included in my mandate they were nonetheless within the scope of my concern.

First is the issue of prevention. Promotion of good health and prevention of disease and disability are crucial to the health of Canadians. Despite having a national infrastructure for public health for many years and despite the efforts of many in this field, it is only in the last decade or so that public health has taken its rightful place as a priority for governments and in the minds of Canadian citizens. Promotion of good health and prevention of disease and disability has an obvious relationship to wait times. Demands on health care systems that could have been prevented make poor use of resources available in the acute care sector. Efforts to limit these demands are important; the responsibility to exercise what control we have over preventable conditions falls both to public health programs and to individuals, institutions and families within our communities. I urge governments to be mindful of this and to ensure that public health and prevention efforts are resourced to do the job that we require of them.

The wait times for First Nations citizens, and for aboriginal people generally, are not addressed in this report. Acute care services are the responsibility of provincial governments. First Nations and all aboriginal people receive acute care services under provincial jurisdiction. These patients are therefore moved through wait lists, schedules, diagnostic services or hospitalization in the same queues with all other Canadians. That is not to say that there are not particular issues of distance or timing that affects care, only that there is no separate acute care track that is particular to aboriginal patients. It is my understanding that the issue of waits is being explored by Health Canada's First Nations and Inuit Health Branch. I do, however, want to lend my support to the future investigation of wait times for First Nation and aboriginal patients. It has been my experience that issues of access to care for aboriginals are especially complex. It would serve us well if this could be addressed fully.

I want to bring to your attention at the onset an issue of terminology that you will undoubtedly note within my report. I refer frequently to "health care systems" when I am describing the health care delivery organizations within provinces. I call these "systems" because they are managed independently by provincial governments, consistent with their jurisdictional right and responsibility. There are some aspects of these systems that are sufficiently similar or interconnected that we can, on occasion, think of our health care system as national in its character and function. Examples of these might be the administrative agreement for reciprocal billing between provinces or the reliance that one province can have on another when assistance is required. Generally the language of the report indicates that while our health care systems are interconnected in some respects and share professional standards and program models, our work to build national consistency and equity, and to collaborate such that we make best use of limited resources, is not yet done.

Conclusion

Although Canada does not have one integrated health care system, provincial systems have evolved with remarkable affinity. Sooner or later each province faces the same set of challenges and works to find solutions that are more alike, one to the other, than they are different. In the next stage of

developing our health care systems we will require leadership in clinical care, innovation amongst managers and professionals and the kind of culture that embraces change, improvement and efficiency. Without these characteristics embedded in our health care systems patients will continue to experience long waits for necessary care and health care professionals will find themselves frustrated by bottlenecks and inefficiencies. Without thorough engagement of the public we will struggle forward without their confidence and encouragement.

Our new federal government is looking to a Patient Wait Time Guarantee to raise the accountability bar for our health care systems. This is a commitment that will surely require careful analysis of implementation options and a thorough dialogue between federal, provincial and territorial governments. I believe that my recommendations are very relevant to this dialogue. In order to achieve the level of performance that a Patient Wait Time Guarantee implies, we will need to take all steps necessary to maximize the system's efficiency and effectiveness.

As a result of my consultations it has become clear that the decision-making that is undertaken between levels of governments is sometimes overburdened. The complexities are such that agendas are full and officials challenged to do their own work and the work of collaborating as well. It appears that the role of advisor, in this case for wait times, has been a useful role. Arm's length, the role has had sufficient autonomy and sufficient time to encourage discussion and develop ideas. As similar issues arise it may be that a similar model will be useful again.

Chapter 1: Introduction

1.1 Background

In recent years there has been an increasing attention to the state of Canada's health care system. Family doctors are in short supply, wait times for surgical procedures are increasing and emergency rooms are experiencing heavy patient loads resulting in lengthy wait times. We all know someone who has felt the affects of these conditions in some way. Federal, provincial and territorial governments continue to collaborate to find remedies to these problems and by doing so to relieve mounting pressures on health care systems. First Ministers' meetings deal with many issues but an ongoing concern has been how to sustain the public health care system and implement efficiencies while at the same time providing comprehensive care to all Canadians in a timely manner.

The *2003 First Ministers' (FMM) Accord on Health Care Renewal*² and the *2004 FMM 10-Year Action Plan to Strengthen Health Care*³ reflected Canadians' concern that the health care system needs to respond more quickly to the public's needs. It also reflected the desire of First Ministers and Ministers of Health to increase accountability to Canadians. First Ministers intuitively understood that Canadians needed improved access to quality care.

In a separate but related event, the Supreme Court of Canada, in June 2005, made its decision on the Chaoulli-Zeliotis case, which resulted in the ruling that the Government of Quebec could not prevent the sale of private insurance for health care procedures covered under the provincial public health insurance plan. A majority of judges agreed that some health care wait times are unreasonably long and violate the rights of individual Canadians. Public interest in the wait time issue and the need for government progress for a solution relating to issues of access has increased as a result of this decision. It brought timeliness into the definition of access in a way that was new to the Canadian health care scene.

In 2004, \$41.3 billion in additional federal funding was committed for multiple initiatives to improve the Canadian health care system. Of this, \$5.5 billion was set aside for wait time-related initiatives. The fund has allowed the provinces increased flexibility to respond to their own wait time priorities and has assisted them in building capacity to measure, monitor and manage wait times across the country. A year and a half later substantial progress has been made on these commitments by federal, provincial and territorial governments.

Health Ministers were also charged with the dual objectives of better management and measurable reduction of wait times in five priority areas (cancer, cardiac, diagnostic imaging, joint replacements and sight restoration). In order to achieve these goals governments agreed to establish comparable indicators and evidence-based benchmarks for wait times by December 31, 2005 and multi-year targets to permit patients to receive care consistent with established benchmarks by December 31, 2007.

² *2003 First Ministers' Accord on Health Care Renewal* is available on the Health Canada website found at: http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html

³ *2004 FMM 10-Year Action Plan to Strengthen Health Care* is available on the Health Canada website found at: http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html

Federal, Provincial and Territorial Health Ministers announced evidence-based benchmarks on December 12, 2005 for “five types of non-emergency surgery, radiation therapy and cancer screening.” These benchmarks were developed from evidence identified in part by the Canadian Institutes of Health Research (CIHR), commissioned by provinces for this purpose. These benchmarks represent a major step forward to achieve the progress that First Ministers intended. The achievement was not however perfect. In general there is scant evidence on which to base benchmarks. In the area of diagnostic imaging, for example, it was not possible to declare benchmarks for CT scans or MRI’s definitively. These will require more research before benchmarks can be identified.

Public Awareness about Wait Times

For the majority of the Canadian public the health care system and health care issues represent the number one priority for federal, provincial and territorial governments. Polls have indicated that 49% of Canadians believe current hospital (and clinical) wait times for surgical procedures are unacceptable and that Canadians wait an unreasonably long time for access to health care services.⁴

In recent years Canadians have expressed concern about the health care system in general. This concern has grown out of a waning confidence in governments’ ability to support and sustain the system as well as Canadians having direct experience with wait times for diagnostic tests and surgical procedures that they consider too long. Cancer patients waiting for radiation treatments and individuals suffering from pain or increasing disability due to hip and knee conditions grow understandably frustrated with lengthy waits to receive care. “Consistently, Canadians identify long wait times as the number one barrier in accessing health services.”⁵ This barrier has become the focus for the federal, provincial and territorial governments who are working diligently to address these concerns.

The Health Council of Canada in June 2005 shared its view of the perspective of Canadians and the resonance that they felt with the FMM decisions of November 2004:

The Canadian public understands that wait times and wait-list management are complex issues that will require time and national coordination if they are to be addressed. Despite this complexity, the objectives of a national approach to improving wait times are basic and speak to Canadians’ core needs and values. Citizens want to feel confident that when they need it, they will get access to health care within a time frame that does not significantly compromise their health or well-being – and they want a system that is fair, providing the sickest people with the fastest access to care without compromising access for those whose needs are less urgent but no less real. These principles of the importance of individual access to care and equity at the system level should guide all decision-making around wait-list

⁴ *Eye on Health, Summer 2005*, p.6.

⁵ Health Council of Canada, *A Background Note on Benchmarks for Wait Times, November 2005*. (Ottawa: Health Council of Canada, 2005), p. 1.

management and must trump the interests of providers, administrators and governments.⁶

Canadian Wait Time Project (CWTP)

Following the commitment of First Ministers to develop evidence-based benchmarks, the federal government made a decision to appoint an independent advisor to aid with the complexities of the ongoing FPT process. I was appointed as The Federal Advisor on Wait Times in July 2005 with a mandate (Appendix A) to undertake activities to ensure “meaningful reductions in wait times” and to “identify and continue to develop consensus on establishing comparable indicators and evidence-based benchmarks”. In addition I was mandated to examine the health care system, address existing knowledge gaps and encourage the adoption of tools and methods to better manage wait times. These goals were to be achieved through dialogue with provinces, territories and stakeholders, such as health care providers and health system researchers.

An intergovernmental advisor, a communications advisor and an executive assistant, all seconded on a part-time basis from the Winnipeg Regional Health Authority (WRHA), supported the Office of the Federal Wait Times Advisor. In addition my office was served by a group that came to be known as the Canadian Wait Times Project (CWTP), which consisted of a full time director, two policy analysts and an administrative assistant located at the WRHA and an additional analyst on a part time basis towards the end of the project. Funding for staff, travel and accommodations were provided by Health Canada. The project office operated at arms’ length from Health Canada.

An independent, external Advisory Group was established early in the project to provide direct advice and support throughout the project. The Advisory Group held one face-to-face meeting and three teleconference meetings at various stages. The members of the Advisory Group, individuals and organizations that contributed to this report at various levels throughout the consultation process are listed in Appendix F. I owe a debt of gratitude to each one of these individuals for their expertise and their contribution to my understanding of the wait time issue and the larger issues of transforming the Canadian health care system.

Activities of the Federal Wait Times Advisor

It was apparent at the onset of this task that FPT governments were engaged in work to meet the commitments of the *10-Year Plan*. Many advances had been made at all levels of the health care system to reduce wait times, some more visible than others. Political leaders and governments had committed human and financial resources and by doing so had raised public confidence that wait times could be and would be reduced. Provinces have since funded Regional Health Authorities (RHA’s) to invest in improved capital and technological capacity as well as additional health human resources. Health care professionals are making changes deep within clinical settings and systems to make care more efficient and more timely.

⁶ Health Council of Canada, *Ten Steps to a Common Framework for Reporting on Wait Times*, June 24, 2005

1.2 Overview of Phase I

The commitment of First Ministers to establish evidence-based benchmarks by December 31, 2005 meant that the project naturally evolved into two phases. Activities in Phase I focused primarily on provincial and territorial engagement in order to achieve the benchmarks. Phase I also served as a period to receive initial feedback and support for the concepts of system transformation that in my view are required not only to sustain the effort that began with the first set of benchmarks, but to substantially reduce or eliminate wait times in the longer term.

Our regular meetings were initiated with the Ministers and Deputy Ministers of Health across Canada. Personal visits took place in provincial capitals throughout the fall of 2005 with provincial Deputies and with territorial Deputy Ministers as a group. The goal of these discussions was to ensure that my work was supportive of individual jurisdictions, each with their own challenges associated with wait times, but also so that my mandate could encourage further collaboration.

In addition to the process of consultation with provinces and territories I was provided many opportunities to present at conferences and meetings to promote a broader understanding of my mandate as Federal Advisor and, more importantly, to receive feedback on key issues facing the health care system and relating to wait times.

Finally many national health agencies and provincial and national federal groups have had strong commitments to improving the health system of Canada. I had the privilege of exploring issues of wait time management with these groups over many opportunities for discussion. A complete list of presentations can be found in Appendices E and F.

Some may note that this discussion about wait times does not address First Nation or aboriginal issues. For the purpose of this report wait times are a part of acute care services. Acute care (largely the provision of physician and hospital services) falls exclusively within the jurisdiction of provincial governments. Consideration of issues associated with acute care wait times therefore encompasses all acute care patients in provincial delivery systems, including all aboriginal patients.

The primary objective of the Phase I of the Canadian Wait Times Project (July to December 2005) was to assist in finalizing the work begun by the provincial and territorial governments to establish wait time benchmarks in the five priority areas of cancer, cardiac care, diagnostic imaging, joint replacement and sight restoration.

A secondary objective during Phase I was to develop and promote the understanding of common definitions for key wait time terminology such as benchmark, indicator, access target and wait time. To facilitate the use of common, accurate definitions a technical briefing was held prior to the formal announcement of the benchmarks.

The Canadian Institutes for Health Research (CIHR) assisted the provinces and territories by developing evidence to support the declaration of benchmarks. Benchmarks (Table 1.1) with the exception of diagnostic imaging, were announced by FPT governments immediately following a technical briefing on December 12, 2005. The announcement not only provided the formal details of the benchmarks declared by the provinces and territories but also established authoritative voices related to wait times management.

Table 1.1: Benchmarks Announced December 12, 2005

<u>Priority Area</u>	<u>Service</u>	<u>Wait Time Benchmark</u>
Cancer	<ul style="list-style-type: none"> • Curative Radiotherapy 	<ul style="list-style-type: none"> • within 4 weeks of being ready to treat
Cardiac	<ul style="list-style-type: none"> • Coronary Artery Bypass Graft 	<ul style="list-style-type: none"> • Level 1: within 2 weeks • Level 2: within 6 weeks • Level 3: within 26 weeks
Sight Restoration	<ul style="list-style-type: none"> • Cataract 	<ul style="list-style-type: none"> • within 16 weeks for patients who are at high risk
Hips & Knees	<ul style="list-style-type: none"> • Fixation of Hip Fractures 	<ul style="list-style-type: none"> • within 48 hrs
	<ul style="list-style-type: none"> • Hip Replacement 	<ul style="list-style-type: none"> • within 26 weeks
	<ul style="list-style-type: none"> • Knee Replacement 	<ul style="list-style-type: none"> • within 26 weeks
Diagnostic Services	<ul style="list-style-type: none"> • Mammograms 	<ul style="list-style-type: none"> • women aged 50-69 every two years
	<ul style="list-style-type: none"> • Cervical Screening 	<ul style="list-style-type: none"> • women starting at 18 yrs old, every three years to age 69 after two normal pap smears

1.3 Overview of Phase II

With the declaration of benchmarks, the focus in Phase II of the project turned to the promotion of a more fully developed strategy for transforming the health care systems that would build upon and sustain the efforts that began with benchmarks. This work involved further consultation with provinces and territories, many presentations and discussions. The second round of meetings with the provincial and territorial Deputy Ministers of Health included more specific discussions on the various elements of system transformation and frequently included other provincial health system officials who were able to bring additional expertise to the table.

Consultants were obtained under contract to undertake qualitative research to inform the content of this report in the areas of management and innovation, professional roles and responsibilities, surge capacity and public education.

In addition, three invitational workshops were held. The first, held in Winnipeg on December 9, 2005 and the second, on March 17, 2006 in Toronto were useful in fully understanding the complex issues that would be the subject of research on benchmarking and system change discussed in Chapter 2. The third meeting held on March 2, 2006 in Winnipeg addressed issues associated with professional roles and responsibilities. This discussion informed Chapter 5 of this report.

1.4 Conclusion

Canada-wide consultations with provincial and territorial governments, many health care professionals, academics and managers have aided in the completion of this report. I believe that my recommendations reflect the varied perspectives and some of the hard thinking that are necessary to bring about change.

Chapters 2 through 8 will detail the thinking behind the recommendations of this report. It may appear that there is an endless inventory of choices for innovations and change. But in fact while choices are indeed many, they are not entirely optional. I believe the five strategies that are presented are interdependent – they go hand in hand to ensure the change that we have begun will continue, wait times will be reduced and Canada's health care systems will perform better and produce better patient outcomes.

Chapter 2: Benchmarks, Indicators and Ongoing Research

Progress has already been made to improve access to health care across Canada. First Ministers and Ministers of Health have been concerned with the public perception of health care and access to services, both in terms of the availability of quality care and wait times. As a result there have been serious efforts over a number of years to build upon the solid foundation of health care services in Canada.

Provinces under the Canadian constitution have the responsibility for direct service delivery of health care. Provincial delivery systems have developed over time around trends in the provision of medical services nationally and internationally and in response to specific needs of provincial populations. Provinces may provide a similar range of services, by similar professional groups, though the organization of the service means of delivery might be quite different.

On the national front, *The Hospital Insurance and Diagnostics Act (1957)*⁷ was the “largest governmental undertaking since the war and would require federal-provincial cooperation on a scale never before known” providing all Canadians with access to uniform hospital services. The *Medical Care Insurance Act* followed in 1967. *The Canada Health Act (1984)* further levelled the playing field by banning extra billing and user fees associated with both medically necessary hospital and medical care. Criteria were established in support of a health care system that is universal, accessible, portable, comprehensive and publicly administered. Efforts to preserve the process of equity and comparability continue to this day.

The recent topic of benchmarks and indicators speak to issues of standards and comparability. Provinces have developed data systems to meet their own needs. There is now a need to develop systems with common data elements to bring definition and consistency in reporting to Canadians. For example, the use of common indicators to measure progress in meeting benchmarks across the country would contribute to this objective.

2.1 The 10-Year Action Plan to Strengthen Health Care

In September 2004 First Ministers agreed to the *10-Year Action Plan to Strengthen Health Care*. The *10-Year Plan* committed the provinces and territories to reduce wait times in priority areas, while recognizing the different starting points, priorities and strategies across the country. To accomplish this, Ministers of Health were charged with a commitment to establish evidence-based wait time benchmarks beginning with five areas: cancer, cardiac, diagnostic imaging, joint replacement and sight restoration. In addition each province and territory agreed to set multi-year targets to meet the benchmarks by the end of 2007. A third commitment was for provinces and territories to establish comparable indicators of access to health care professionals, diagnostic procedures, and medical treatments.

⁷ Taylor, Malcolm, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created The Canadian Health Insurance System and Their Outcomes*, 2nd Ed., 1987.

2.2 Terminology

Health scientists do not always agree on definitions for such things as benchmarks, indicators and access targets. When other health professionals such as health bureaucrats, politicians or the media enter into the discussion a consensus is even harder to achieve. It was clear to me early in this project that there was an absence of clear definitions in debate, discussion and media reports that was making the work of wait times harder. There is a need to promote the understanding of accurate wait time terminology for the public, the media and health care providers as well.

What is a wait time?

The federal, provincial and territorial announcement on benchmarks on December 12, 2005 established the following definition of wait time:

A wait time begins with the booking of a service, when the patient and the appropriate physician agree to a service and the patient is ready to receive it. The appropriate physician is one with the authority to determine the nature of the needed service. A wait time ends with the commencement of the service.⁸

What is a benchmark?

Wait time benchmarks are evidence-based goals that express the amount of time that clinical evidence shows is appropriate to wait for a particular procedure or diagnostic test.⁹ A benchmark may be identified when scientific evidence shows that the outcome of an intervention is negatively affected after a certain period of waiting has elapsed. The nature of a benchmark, due to the evidence that supports it, is such that it does not change from one system to another.

What is an indicator?

Indicators are used to measure how well a system is performing in relation to a benchmark. Comparable indicators have the additional benefit of allowing comparisons across health systems, for example from one province to another. Indicators rely on data collected consistently from one site to another.

What is an access target?

Evidence-based benchmarks have application nationally. Targets, on the other hand, may be set by each province and territory based on the jurisdiction's practical capacity to achieve them. As agreed to in the *10-Year Action Plan*, targets are interim performance goals set by each province/territory over a period of time to guide work towards the achievement of the benchmark. A target is discretionary, and can take the form of a performance goal.

⁸ FPT Announcement, December 12, 2005

⁹ The definition used for the purpose of this report is based on the terminology agreed to by Provinces and Territories and announced publicly on December 12, 2005.

2.3 Using benchmarks to provide timely access

Measurements against benchmarks will allow Canadians to see how well their province is performing to provide timely access to selected health services. In order to make benchmarks work other system changes are required, all of which provinces are working on:

- Using information technology to collect data on wait times and measure progress;
- Improving the way services are delivered to make them more efficient and patient-focused;
- Managing access using consistent criteria to assess the needs of patients and how urgently they require care;
- Clarifying how managers and health providers are responsible for enhancing access to care;
- Evaluating access to health services and health outcomes to help determine where resources should be directed for the most effective results; and
- Communicating clear information to Canadians who have an interest in wait times.

2.4 Using indicators

Indicators are necessary to measure progress against benchmarks at a later date. Comparable indicators have been used to report annually to Canadians on key areas identified by First Ministers even before the declaration of the benchmarks in December 2005. The September 2000 First Ministers' Communiqué on Health gave direction to Health Ministers to develop a "comprehensive reporting framework, using jointly agreed upon comparable indicators of health status, health outcomes and quality of service"¹⁰. In September 2003, fourteen jurisdictions including the federal government released reports to their citizens. The February, 2003 *First Ministers' Accord on Health Care Renewal* directed Health Ministers to develop additional indicators to supplement the previous work on comparable indicator reporting. Provincial reports were released in 2004.

Provinces and territories have now established comparable indicators for health services that have common benchmarks, such as cardiac bypass surgery, radiation therapy for cancer, and cataract surgery, to track how well they are improving access to care. Using these indicators, each province and territory will be able to report on access to selected health services. For example, each jurisdiction will be able to identify wait times for hip and knee replacements, and the public will be able to compare results across Canada. The indicators, endorsed by the provinces and territories to meet the commitments of the *FMM 10-Year Action Plan to Strengthen Health Care*, were communicated to Health Canada's Deputy Minister in a letter dated March 30, 2006.

¹⁰ The September 2000 First Ministers' Communiqué on Health

2.5 Using access targets

Access targets are another vehicle for developing reasonable standards of care. Access targets can be developed at the provincial level and may reflect the policy or program direction of the provincial government. Provinces and territories have the option of identifying access targets that will motivate the system to improve on wait times for other conditions if they think it appropriate. Access targets could be developed based on consensus of professionals if evidence is not yet available or sufficient.

2.6 Ongoing research to support wait times

The declaration of the first set of benchmarks has given us an evidence-based foundation for measuring progress in reducing wait times in the future. It is my belief that if we are to sustain the work that began with benchmarks, a process for ongoing research and decision-making is needed to guarantee the process is transparent to care providers and the public.

It is my view that future benchmark research should take into account issues of cost and appropriateness. These are issues new to the development of benchmarks and warrant brief discussion here.

Cost per case is an important concept because when a procedure is refined, quality measures have been incorporated and criteria established to determine timeframes and eligibility, the next logical assessment is related to cost per case. Not all procedures, interventions or surgeries can be costed definitively. Many procedures are complex and may be affected differentially by the acuity of the patient or by other factors. But for many procedures that are commonplace in our health care systems, it is possible and desirable to ensure that the cost by unit is comparable from one site to another. It is a necessary step in fulfilling our responsibility to ensure that our resources are used wisely.

Appropriateness is also relevant to benchmarks. Not all patients benefit equally or benefit at all from a particular intervention. Research with respect to benchmarks should tell us not only if an intervention cannot be delayed, but also if and when the procedure is appropriate.

The benchmarks that were announced on December 12, 2005 were established as a result of research undertaken by researchers whose proposals were peer-reviewed. Benchmarks were declared after provincial and territorial Deputy Ministers of Health received advice from the Canadian Institutes for Health Research (CIHR)¹¹ and recommended to Ministers of Health that the benchmarks be accepted as evidence-based and used to set standards for appropriate wait times for care.

We propose that CIHR develop a plan to address research associated with benchmark development.

¹¹ The Canadian Institutes of Health Research (CIHR) is the Government of Canada's lead agency for health research with a mandate to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system. (CIHR website: <http://www.cihr-irsc.gc.ca/e/22948.html>)

These fall into two areas:

- Research to develop new knowledge that will allow us to establish and declare additional evidence-based benchmarks in the future.
- Health system (operational) research that will result in improvements and interventions in system processes, including the evaluation of the first set of benchmarks to assess their impact on health care outcomes.

The Benchmark Research Agenda

We have not yet tested the affect that benchmarks will have on patient outcomes and on health care systems. This is an important first step in deciding whether additional benchmarks in other clinical areas should be developed. When the time comes to identify additional benchmarks two key issues must be addressed:

- a process to identify priority conditions for developing benchmarks; and
- responsibility for recommending benchmarks and where responsibility lies for declaring national benchmarks.

It is critical that there be an ongoing research process to sustain the effort that began with the declaration of the first set of benchmarks. Our first attempt to produce benchmarks in the five areas identified by First Ministers offered many challenges. Peer-reviewed research in these areas was scant. It was not possible, partly because of the timeframe that is required to mount a request for proposals and to identify suitably qualified researchers from relatively small pools of experts, to identify benchmarks in all five areas. Research to identify cancer related benchmarks and diagnostic imaging benchmarks (for CT scans and MRI's) were not identified.

Given the resources that benchmarked care will attract or require, we can expect many clinicians and patients to put forward their choices for benchmarks early on. It is important to determine how the next set of benchmarks will be chosen. This will require a process to establish who decides what research will be undertaken, the order of priority; what condition, procedure or category the research will focus on for a potential set of new benchmarks. These efforts must be undertaken collaboratively between the research community and governments. It may be that CIHR's research institutes, put in place to focus on research needs in major medical disciplines can play a role in this respect as well.

It is equally important to decide who will have the responsibility for declaring benchmarks once research has been conducted and evidence is available. It is my view that a "trigger group" consisting of researchers, clinicians and senior officials of government should be responsible for recommending to elected officials the declaration of future benchmarks. I believe that it is necessary for participants to share responsibility for recommendations and to consider perspectives other than pure research. Ministers of Health can have, as a consequence, confidence that a broad range of implications have been considered.

The Health System (Operational) Research Agenda

A substantial amount of work is taking place across the country on issues related to system improvement. This kind of research depends upon root cause analysis that examines roles and procedures associated with care, to identify where efficiencies are absent and bottlenecks exist. Operational research can document patient flows and time procedures, propose change and evaluate its success in meeting new goals. It can examine the role that technology plays in efficient care and also that of care providers, the public or the media play in embracing change or rejecting it. It is in this area of research that the business and industrial practices successful in other fields can be evaluated for application in operating rooms, wards and diagnostic clinics. The machinery of our health care systems - process and flows, organizational design and incentives can be tested to determine whether it supports or hinders wait time efforts.

The Networked Centres for Health Innovation

Despite the fact that many industries and businesses use queuing theory and industrial practices routinely to streamline their processes, the application of this thinking to health care systems is relatively rare. We have not sufficiently exploited the academic resources available to us from business management schools or industrial engineering. CIHR has proposed that a networked partnership be created between existing health services research centres to develop capacity in management practices. This network is conceived as a partnership between the federal government (represented by CIHR) and provinces to build on existing expertise and collegial relationships in health care systems. Researchers, health care practitioners, health system managers and policy makers could work in collaboration on activities to:

- identify high priority issues and plan research studies on topics within those areas;
- plan knowledge translation activities;
- evaluate the impact of activities on performance of health care systems;
- communicate findings; and
- examine the work of other centres and apply them as appropriate.

2.7 Conclusion

Establishing benchmarks for medical care is a new phenomenon in Canada's health care system. It is too early to know the impact of using benchmarks.

The research described here is proposed to help us find out the effects, to refine or approve our methods and move on to new solutions if need be. CIHR has systems in place to manage these research processes and the mandate to ensure that new knowledge is transferred to decision-makers and care providers.

Chapter 2: Benchmarks, Indicators and Ongoing Research Recommendations

1. That the Canadian Institutes of Health Research (CIHR) undertake research to:
 - evaluate the effect of the benchmarks established through the FPT process;
 - broaden the scope of benchmark research to include the cost and appropriateness criteria; and
 - identify areas in which additional benchmarking is required or desirable to improve patient outcomes.
2. That multidisciplinary, collaborative panels (including researchers, clinicians and government representatives) be established to review evidence and recommend additional benchmarks to FPT governments;
3. That CIHR develop additional capacity through existing health policy institutions across Canada to enable them to study best business and industrial practices to support wait time reductions.

Chapter 3: Management and Innovation in Health Care Systems

The development of benchmarks and targets against benchmarks were a necessary short-term goal to meet the commitments made by First Ministers in September 2004. However, the concerted efforts that have been taking place over the last few years to shorten wait times will not be sustained unless the machinery of health care systems are transformed. Without these transformations it is unlikely the system will be able to sustain these wait time reductions without significant financial infusions. Our goal must be to ensure that the recipient of care, *the patient*, processes and quality of care are the first priority of caregivers and care systems.

There are improvements that can be made now within existing health care systems that will have long-term effects. These include:

- adoption of new management, business and industrial practices¹² by provinces and territories, regional health authorities and health care institutions;
- development of wait time coordination expertise in provincial and territorial health care systems including wait time champions and coordinators who assist both patients and their families to navigate complex health care systems; and
- development of a training program for current clinical leaders, nurse managers and other health care professionals in wait list management practices.

We already know from experience that the maintenance of individual wait lists by individual specialists contributes to lengthy waits for some patients. Opportunities for earlier care, perhaps with another specialist, are often missed. Our system will benefit from:

- use of single common waiting lists;
- an approach that permits patients to be referred to a speciality service that prioritizes the patient by acuity and offers the first available slot for intervention;
- the use of queuing theories to alter current processes;
- innovative case management;
- team based care;
- appropriateness; and
- pre-habilitation programs to ensure fitness for surgery.

¹² You will note that this report refers to managerial, industrial and business practices and/or innovations. For the purposes of these discussions managerial practices refer to issues of governance, supervision, planning, accountability, comptrollership – those functions that are normally associated with managerial responsibility; industrial refers to the creation of efficiency through techniques and mechanisms that expand on collective human labour and make for the best use of time, capital and human resources; business practices in the context of health care refers to administrative processes including communication, data collection and sharing, paper flow and record keeping.

Pre-habilitation may allow for improved fitness for surgery and fewer cancellations. Weight loss, blood pressure control, and blood sugar control can all be improved through these processes. A patient would only enter a wait list when they were fit to do so and when benefit is minimized.

The attention given to unacceptably long waits over the last several years has given us insight into how wait times can be reduced or eliminated. This chapter explains why waits exist and provides an inventory of necessary system innovations. All decision-makers and health care leaders must be aware of this body of knowledge. These innovations are now being implemented in many sites throughout Canada and show great promise. Finally, there is a growing interest in issues of appropriateness. The first issue of appropriateness pertains to the choice of care the patient will receive; the second issue relates to appropriate and efficient use of available resources.

3.1 Why are there waits for services?

There are a variety of factors that influence wait times:

- the type of care that the patient requires;
- the doctor whose list the patient is on;
- how urgently the patient requires care;
- other factors related to individual patient needs or conditions.

Capacity is usually not measured¹³

Typically the providers of health care services know their activity or utilization level but may not know their capacity or demand. For example, in primary health care settings, there are patients that phone for appointments but are turned away. These individuals may go elsewhere or not seek care at all. This means that appointment books reflect only those individuals who successfully schedule an appointment. In order to accurately measure demand it is necessary to record calls where an appointment has been requested and refused.

In addition, actual capacity is usually unknown. One example is the practice of routinely scheduling treatment based on thirty-minute intervals when the average procedure may take only 17 minutes.¹⁴ A study has shown that bookings were done on this basis “because some procedures took 30 minutes”. In this instance there was almost 50% more capacity than was being utilized.

Appropriateness of care

Appropriate health care is when the health benefit exceeds the negative consequence of not having treatment by enough of a margin to justify treatment.

¹³ Refer also to Chapter 6: Additional Issues: 6.2 Surge Capacity p. 52-58

¹⁴ M. Carter, *Evidence for Improvement vs. Evidence for Judgment: Choosing the Appropriate Tools for the Task*. Sixth International Conference on the Scientific Basis of Health Services. (Montreal. September 20, 2005).

The University of British Columbia (UBC) evaluated the indications and outcomes for six elective surgical procedures and reported the findings in 2002 in the *Canadian Medical Association Journal*. The UBC study found that 94% of elective hip replacement patients were better after surgery, 4% were unchanged in their symptoms, and 2% were worse.¹⁵ On the other hand, only 70% of cataract surgery patients were improved while 26% actually had worse vision after the procedure. It appears that most of the joint replacement patients were getting appropriate care while many cataract patients were not. If one-quarter of Canadian cataract surgery patients should not have surgery at all, wait lists for this procedure could be eliminated or substantially reduced.

Another example of appropriate use of health care services is demonstrated by the use of the Ottawa Ankle Rules.¹⁶ We know that the Ottawa Ankle Rules can decrease the need for x-rays by up to 40% while not actually missing anyone who has a broken bone.¹⁷ A study of Canadian emergency physicians showed that less than one-third of these physicians were using the rules correctly.¹⁸ The implementation of The Canadian CAT (Computed Axial Tomography) Scan Rule for patients with head injuries¹⁹ has the same potential to reduce the need for CAT scans in these instances by 40% or more.²⁰

3.2 A perspective on health care waits and delays

Canadians need to be aware that just because there is a wait for care does not mean that the wait is medically unacceptable. However nobody wants to wait, or should wait, months for an artificial joint while suffering pain or disability. There may be other circumstances in which it is convenient for a patient to delay major surgery by a week or two to wrap up loose ends or make arrangements with family or friends to assist with their impending recovery. As well, some patients in consultation with their physicians may prefer to delay surgery for “pre-hab”.²¹

Sometimes it is the unpredictability of a delay rather than the length of the delay that presents the problem. For example, people often have to make special arrangements for care of their home or dependents when they have surgery. Having a specific date for surgery may allow time to mobilize family and friends. Without a specific date or with a cancellation, it can be difficult or impossible to make such arrangements.

¹⁵ C.J. Wright, G. Wright, K. Chambers, et al., “Evaluation of indications for and outcomes of elective surgery”, *Canadian Medical Association Journal*. 2002;167:461–466.

¹⁶ Stiell IG, Greenberg GH, McKnight RD et al. “Decision rules for the use of radiography in acute ankle injuries: refinement and prospective evaluation”, *Journal of the American Medical Association*. 1993; 269:1127-1132.

¹⁷ J. Heyworth, Ottawa ankle rules for the injured ankle. 2003;326:405-406.

¹⁸ J.C. Brehaut, I.G. Stiell, L. Visentin, et al. “Clinical decision rules in the “real world”: how a widely disseminated rule is used in everyday practice”. *Academic Emergency Medicine*. 2005;12:948-957.

¹⁹ I.G. Stiell, G.A. Wells, K.L. Vandemheen, et al. “The Canadian CT head rule for radiography in alert and stable trauma patients.” *Journal of the American Medical Association*. 2001;286:1841-1848.

²⁰ I.G. Stiell, C.M. Clement, B.H. Rowe, et al. “Comparison of the Canadian CT head rule and the New Orleans criteria in patients with minor head injury” *Journal of the American Medical Association* . 2005;294:1511-1518.

²¹ Pre-hab is rehabilitation prior to the procedure the goal of which is to hasten recovery.

3.3 Best practices and efficiencies

Healthcare is sometimes compared to a “cottage industry”. Over time each province, region, facility and doctor’s office has developed their own best practices designed to meet their individual needs or those of their patients. It is only natural that they would feel the pride of ownership for having created systems or process that have shown success. Difficulty arises from the fact that while there are many innovative ideas that are in practice across Canada these ideas are not shared across jurisdictions. This means that our health care system is really a patchwork of systems often lacking efficiency and resistant to change when new best practices are identified.

Many best practices exist and could be replicated. One example is the Kingston Surgical Booking system, which was developed over eight years, and now provides an overall view of the city’s surgical waiting list. It keeps track of the actual time taken for individual surgeons to perform different procedures and to ensure most efficient booking of procedures. The system also provides alerts for pre- and postoperative care. It can warn clinicians about the need for a lung function test prior to surgery or the need for a rehabilitation bed after surgery. Chapter 4 will address the importance of information technology in these activities as it relates to system transformation and the reduction or elimination of wait times.

One of the more recent applications of better business practices is the Alberta Orthopaedic Clinic Pilot Project.²² Initially the project attempted to have referring doctors complete a referral template to ensure that appropriate investigations had been completed. However, as the project progressed it was found to be easier to place family doctors into the clinics to assist with the initial work up of patients. Patients are assigned to case managers who track them throughout their care.

Specialization

Specialization is another means of achieving efficiencies within health care systems. There are many examples of specialized centres. Toronto’s Queensway Surgicentre, a division of the Trillium Health Centre (a public hospital) is the largest not-for-admission surgical centre in North America. Another example in Manitoba is the provincial government purchase of the Pan-Am Clinic from its private sector owners. The Clinic now operates as a unit of the Winnipeg Regional Health Authority (WRHA).

Leadership

There are many examples of leadership that have resulted in innovative ideas. It will serve our systems well to identify individuals who are trained, who have leadership abilities and clear and measurable objectives to bring about change. Too often healthcare organizations have little capacity to take on quality improvement projects. These can be a significant barrier to innovation. In many instances, a barrier to making an innovative improvement is that health care organizations until recently have had little capability for quality improvement projects.

²² Alberta hip and knee replacement project: Interim results. Alberta Bone and Joint Institute. December 2005. Found at: http://www.albertaboneandjoint.com/PDFs/Int_Rep_Dec_19_05.pdf.

To effectively engage in quality improvement an organization must:

- include quality improvement in its strategic plan;
- provide leadership;
- ensure resources are available to support quality improvement activities;
- develop measures to assess quality and have regular quality monitoring; and
- ensure that feedback is provided with reports to the appropriate unit and up through the organization.

Role Definition

Discussions on health human resources have for many years focused on capacity - the number of training spots available in medical schools, universities and colleges, recruitment, retention and repatriation initiatives. Supply is an important health human resource issue, but so is role definition. Role definition with respect to the current workforce is relevant to wait time management. For example, nurse anaesthetists have the potential to relieve surgical backlogs resulting from a shortage of anaesthesiologists and nurse practitioners, working within their scope of practice, can assume broader clinical functions in primary care settings. Enhancing the role of various health care workers increases capacity and makes more appropriate use of physician time. Chapter 5 will address this issue as well.

3.4 Models for quality improvement

There are models for quality improvement that have shown success and are in use both internationally and nationally. One example is the UK's National Health Service (NHS) Institute for Innovation and Improvement.²³ The Institute was created to lead a quality improvement activity that applies evidence to practice by encouraging clinical teams within organizations to test changes. The Institute has also used a collaborative model where teams from different organizations work on the same issue over the course of 6-12 months and compare the results. This initiative has achieved significant reductions in wait times in the UK over the past six years.²⁴

The Saskatchewan Health Quality Council has developed its own process to improve access. The Council draws upon the experience of organizations that have demonstrated success with a particular initiative.²⁵ For example the Saskatoon Community Clinic implemented an "advanced access" system a number of years ago. Staff from the Clinic are presently assisting the Health Quality Council to implement province-wide, same day access to primary health care by 2010.

²³ For more details see: <http://www.institute.nhs.uk/nhsinstitute>.

²⁴ G. Bevan, C. Hood, "Have targets improved performance in the English NHS?" *British Medical Journal*. 2006;332:419-422.

²⁵ For more details see:

<http://www.hqc.sk.ca/portal.jsp?mpqBiB5PkT0FgPM/yFSHnTBIzBf0QfLQkUwK4QBZaJtdpqKPgr7c14zOVcA+ImY4>.

While the collaborative model of quality improvement has had some success, it can be expensive to operationalize. A recent review observed that organizations need a commitment to quality improvement to ensure that a collaborative will have an impact on their organizations.²⁶ Organizations which successfully ran collaboratives also attempted to create a culture for quality. They focused on process and outcome measurement to drive change.

3.5 Modern methods of queue management

Queuing Theory

Queuing theory is a branch of mathematics that deals with waits and delays. It contributes to the practice of advance access (also called open access).²⁷ Queuing theory can be applied to improve flow whenever something or someone arrives from somewhere else, has something done to them and departs. Applications of queuing theory are used routinely for air traffic control, manufacturing processes, amusement parks and many other aspects of day-to-day life, including inventory control in hospitals. Yet in an area as important as acute care, there has been little use of queuing theory to reduce patient waits in the health care system.

Queuing theory uses various techniques or tools. The following are examples of queuing tools that can make service more responsive to patient waits.

Advance Access

One example of managing waits and delays is referred to as “*Advance Access*”. Many family doctors have wait lists of four weeks or more for routine appointments. Advance access is a method of organizing, scheduling and planning patient flow in office practice with the goal of scheduling appointments on the day of choice, including the same day.

Advance access typically uses this analysis:

- assess whether capacity is sufficient to meet demand;
- if capacity is sufficient to meet demand, temporarily increase resources to clear the backlog;
- if capacity appears insufficient for demand, then attempt to smooth capacity and reduce demand.

If these attempts are unsuccessful, then a bottleneck exists that must be identified and rectified.

²⁶ L.R. Ayers, S.C. Beyea, M.M. Godfrey, et al. “Quality improvement learning collaboratives.” *Quality Management in Health Care*. 2005;14:234-247.

²⁷ For further information on queuing theory see University of Windsor’s Dr. Myron Hlynka’s Queuing Theory at: <http://www2.uwindsor.ca/~hlynka/queue.html>.

Dealing with bottlenecks

In instances where a bottleneck exists, a root cause analysis may be needed to determine if the cause is a result of a shortage of capital, human or other operating resources. There may be instances where new or additional resources are necessary to eliminate the bottleneck. Analysis should be repeated on a regular basis since over time bottlenecks in the process may move around. The goal is to even the flow by reducing variation as much as possible. This is only possible when the whole pathway of care can be seen and managed.

Smoothing Capacity

Smoothing capacity means eliminating the peaks and valleys of capacity that plague health systems. For example, there are more discharges from hospitals on Friday than other days, especially Sundays. That means, in general, hospital staff rush on Friday to discharge patients often competing for orderlies, pharmacy orders and other services. Patients who arrive home with questions may not be able to reach the family doctor or staff who took care of them in hospital.

Health systems also tend to increase variation by creating multiple lines for services for different priority ratings or doctors, similar to a line up at a bank. As we know, more people can be processed when one line feeds all the tellers. When there are separate lines, some lines move more quickly than others. Sometimes, one line will be free when there are lines for the other tellers. In the example of a bank line, it may take a minute or more to identify the long line and move someone over. Frequently it is a person from the end of the longer line, rather than the front or middle of another line that is moved or moves to the free teller. This action compromises fairness.

When delays for health services get long, the numbers of patients who do not attend for their appointments rises. They might have received care elsewhere or simply forgotten that they had an appointment because of the long wait. In addition, some patients deteriorate and may no longer be appropriate candidates for the scheduled care. Staff may call patients who live nearby and are mobile but ignore those who have greater urgency. If the vacant slot is not filled, the capacity is lost and cannot be regained.

Prioritization can actually make delays worse. It is understandable that when there is not enough capacity. Staff will prioritize patients, creating separate categories which result in multiple queues and more capacity/demand mismatches. In most instances there is enough capacity but it is not used efficiently. Doctors usually administer their own wait lists through their offices and as a result some doctors or some hospitals end up with longer lists than others.

It is also the case that more appropriate analysis at the onset of care can reduce demand. Many Canadians face long waits for specialist visits. Throughout Canada, many specialists routinely schedule referrals as one-hour appointments. In some instances it may be possible to schedule a shorter visit or avoid having the patient visit the specialist at all if the issue is not complex and can be addressed with a 5-minute phone call between the family doctor and the specialist. In other cases, the patient (and family) may require a half-day assessment from a multidisciplinary specialist team due to the complexities of the case. Assessing the need before hand could save valuable time that could be used where it is needed most.

Inappropriate use of resources

Inappropriate use of available resources also contributes to lengthy waits for services. An example of this is in the field of diagnostic imaging. We know that there are instances of repeated exams resulting from x-ray films that are inadvertently lost or inaccessible. We know too that wrong exams may be ordered; an exam might not be required at all or x-ray exams are ordered in a process of elimination. Inappropriate use of resources is a major contributor to lengthy wait times and increases costs unnecessarily.

A pilot study undertaken by the Canadian Association of Radiologists (CAR) has shown that only 86% of requests for diagnostic testing were appropriate. In 9% of the cases, a more appropriate test should have been ordered, resulting in a duplication of studies. In 4% of cases imaging was not necessary at all. This means that 10% of referrals or close to 4 million exams per year could have been eliminated. This represents the workload of 200 radiologists.²⁸

Multi-step health care

Most health care encounters involve several steps. For example, arthritis patients usually start off being treated by their family doctors. Eventually, if their joint pain or disability increases, the family doctor will refer the patient to a rheumatologist or an orthopaedic surgeon. After the initial specialist visit, the patient will usually be sent for an imaging study (e.g. X-ray, MRI) and then often be referred to a physiotherapist. At some point in follow up, if the patient is still deteriorating, an orthopaedic surgeon will put the patient on his or her surgical list. At each step in the process, the patient may face months of waiting. Multi-step services such as these can be subject to repeated delays.

When dealing with long waits for several linked services, the first step is to map the whole course of care and evaluate the results. Sometimes, this process will immediately suggest re-design possibilities such as eliminating unnecessary steps, streamlining the number of steps or combining multiple steps.

The use of registries

Earlier in this chapter, in the discussion of best practices and efficiencies, I mentioned the importance of information technology in reducing wait times. Technology plays a key role in many of the queue management techniques as well. Registries, as part of electronic information systems, are essential for better queue management. They have the added benefit of providing valuable data that can be used to evaluate outcomes. At present there is little data collected on patients prior to or after medical procedures. The data collected through registries can be a useful tool for analysis. It has been suggested that the following data be included in wait list registries:

- timeline information including but not limited to original request for consultation with family physician, first appointment with specialist, time of decision about treatment, exit from queue without service, time of service provision, follow up appointments;
- clinical presentation;
- symptom changes over time;

²⁸ Dr. Ben Chan, *Appropriateness of Care: The Story of Diagnostic Imaging*, March 31, 2006.

- co-morbidities;
- reason for delays in care;
- reason for leaving queue; and
- outcomes including mortality, morbidity, and quality of life.

3.6 Provincial wait time champions

There is a need to support clinical leaders as they inspire change within our health care systems. In provinces where governments and health departments have placed leadership and accountability squarely with respected clinical leaders, progress has been significant and visible.

I have described in this chapter many elements of the administration of care that require change, each of these contributing to transformation in one domain or another. The responsibility for the planning and management of these changes must be given to a leader who has interest and expertise in this field, management skill, proven clinical knowledge and the confidence of peers. This is no small expectation. It is clear to me that these individuals exist across provincial jurisdictions and that they can be recruited to assume the leadership that this change process requires.

Such leaders can play a role within their own jurisdiction and nationally as well. In all of these areas of innovation and process improvement, leaders rely on other leaders with whom to share best practices, experiments and ideas. We know already that provinces are conducting their own change processes and that from these efforts many outstanding innovations have been put into place. In order to ensure that this process of change continues and that all provinces are able to share in and learn from the best practices of others, I support the creation of a network of provincial wait time leaders. Governments should identify the necessary resources to develop this network and support it with resources sufficient to address provincial needs and interprovincial collaboration. The development of this network will increase the chance that work will be undertaken with experience and vigour and that the knowledge that is acquired in one jurisdiction can be put to good use in another.

3.7 Navigating the health care system

Difficulties encountered by patients and their families while navigating through complex health care systems are well documented by the media and by various health care analysts. There are countless stories of patients who have either been lost “in a black hole” while waiting for treatment or have had difficult experiences due to inefficiencies within the system. These issues range from minor glitches, easily rectified with a phone call, to major inefficiencies that need to be identified and corrected through root cause analysis. A new staff function called wait time coordinator, navigator or advocate has emerged to assist patients in progressing through treatment processes.

Aside from the benefits to patients and families, navigators can also assist health care providers. In Nova Scotia, oncologists rely upon the navigators to coordinate care. Family doctors and health care centres have come to depend upon their clinical knowledge of the structure and function of the cancer treatment system. The navigator keeps in touch with the family physician’s office during the diagnostic work to ensure that appropriate referrals are being made for further diagnostic tests and

specialists consultations. In addition, navigators coordinate with surgeons' offices to ensure that referrals are being made for radiotherapy and chemotherapy, if required.

Navigators or case managers²⁹ are empowered to challenge the system. Navigators can do more than assist individual patients to solve isolated problems. They can be linked to a quality improvement process that ensures their knowledge about system inefficiencies is passed on to others.

Clarifying the Roles

There are a number of different approaches to addressing the navigator, advocate or wait time coordinator roles but a common factor is the focus on patient-centred care. Job functions can be similar but activities may begin or end at various stages in the patient care. It is possible for the same individual to function as both a wait time coordinator and navigator/advocate.

A *wait time coordinator* is typically assigned to a patient upon booking of a treatment and communicates with that patient until the commencement of the service.³⁰ The wait time coordinator is a designated position within an organization or care network with functions involving case management for a specific group of individuals during the time they are waiting for care (either surgical or diagnostic such as an MRI/CT scan).

A *patient navigator/advocate (system navigator)* involves providing assistance to patients once they have already entered the system (i.e. during a hospital stay). The navigator typically will guide the patient through the system or act as an advocate to speak on their behalf when they may be unable to speak for themselves. System navigators tend to be embedded within other types of case management or coordinator models.³¹

The roles of wait time coordinators, navigators or advocates have the potential to not only provide assistance to the patient (and family) but to include a responsibility to improve patient flow by identifying and reporting on bottlenecks or inefficiencies.

3.8 Training health care professionals

A culture of change is necessary if we are to succeed in transforming the health care systems. It is necessary to train professionals currently working within our health care systems in techniques that will improve flows and shorten wait times. Process improvements are still taking hold in our systems. We need to invest in training to build a community of support and expertise at both individual and organizational levels. The Canadian Health Services Research Foundation (CHSRF) has prepared such an education program known as "Shorter Waits and Improved Flows Training Program" (SWIFT).³² The program provides training through a combination of on-site, sequestered training;

²⁹ These terms are often used interchangeably along with others such as case coordinator, cancer support nurse, follow up nurse and cancer coordinator.

³⁰ The wait time period used for the purpose of this document is based on the definition approved by Federal/ Provincial /Territorial Health Ministers and presented to the public on December 12, 2005 in the announcement on the benchmarks.

³¹ Jamieson, Wanda. *Patient Navigation within the Health Care Sector*. JHG Consulting. 2006; 25

³² Report I: Canadian Health Services Research Foundation (CHSRF), *Shorter Wait and Improved Flows Training Program (SWIFT)*.

web based learning; at-home instruction and an annual face-to-face meeting of fellows and graduates. An ongoing network will continue to support graduates. The program would target clinical leaders, managers, nurse executives, administrators and others who play critical roles in time sensitive clinical care and could be offered in both official languages.

3.9 Conclusion

There are many challenges associated with reducing waits and improving access to health care in Canada. Examples from across the country and around the world demonstrate that it is possible to dramatically reduce waits. Canadians could potentially have same day access to primary health care, one or two week access for appointments with medical specialists, and almost no waiting for tests and surgeries.

Chapter 3: Management and Innovations in Health Care Systems Recommendations

4. A national network of wait time champions (one per province) be established to lead the development and promulgation of best practices throughout provincial health systems;
5. As an extension of the foregoing recommendation, that provincial capacity for wait time coordination in health regions and major institutions be established;
6. That the Canadian Health Services Research Foundation should develop and implement a continuing, multidisciplinary educational program for health care professionals, for the purpose of developing wait list management leadership and skills and for a period of time that equips existing health care professionals to adopt business and industrial practices.
7. That provinces and territories adopt best practices for wait times including:
 - the use of single common waiting lists;
 - an approach that permits patients to be referred to a speciality service that prioritizes the patient by acuity and offers the first available slot for intervention;
 - the use of queuing theories to alter current processes;
 - innovative case management;
 - team based care;
 - appropriateness; and
 - pre-habilitation programs to ensure fitness for surgery

Chapter 4: Information Technology (IT)

The development and implementation of information and communication technologies have become key to ensuring quality health care. In health care systems the importance of technology is in its ability to allow health care providers to share crucial patient information easily and accurately. “Accurate information is crucial if patients are to have choice and receive the right care at the right time... to give healthcare professionals access to patient information safely, securely and easily whenever and wherever it is needed.”³³ In order to provide patients and professionals with the right information at the right place, at the right time, the federal, provincial and territorial governments, through Canada Health Infoway, are working together to establish a pan-Canadian health info-structure that will make information readily accessible to those who need it.

As discussed in Chapter 3, new business practices and system innovations have the potential to have a huge impact when applied to health care systems. “Health care has often been described as the last industry to be revolutionized by Information Technology and Information Management initiatives.”³⁴ The increased use of technology can serve to improve service in hospitals, clinics and at home through the use of tools such as: computerized patient registries, interconnected databases for drugs, diagnostic testing results and electronic health records all of which allow patients and care givers in the health sector to have access to necessary information.

The goal of this chapter is to discuss and recommend IT solutions to improve timely access to health care. Specific IT tools and next steps that are being developed with the help of Canada Health Infoway are also described. These are, in my view, necessary investments in the transformation of health care systems in Canada.

4.1 Current state of the health info-structure in Canada

In September 2000 the First Ministers agreed “to work together to strengthen a Canada-wide health info-structure to improve quality, access and timeliness of health care for Canadians.”³⁵ As a result, Canada Health Infoway was established in 2001 to achieve the “desired future state of information technology for the Canadian health care system.”³⁶ As of 2004-2005, and since Infoway’s inception in 2001, there have been 105 Infoway projects launched in all investment areas (infostructure, registries, diagnostic imaging, drug info systems, lab info systems, telehealth, health surveillance, interoperable electronic health record, innovation and adoption).³⁷

³³ Department of Health, *Putting People at the Heart of Public Services: The NHS Improvement Plan*, (Government of England: London, 2004), p.68

³⁴ Task Force Two, *A Physician Human Resource Strategy for Canada*, p. 1.

³⁵ Med-Emerg Inc., *Discussion Paper on Infrastructure and Technology* for “A Physician Human Resource Strategy in Canada: Task Force Two”, September 21, 2005.

³⁶ Ibid.

³⁷ Canada Health Infoway

The term health info-structure refers to:

... the development and adoption of modern systems of information and communications technologies (ICT's) in the Canadian health care system which would allow the people of Canada (the general public, patients and caregivers, as well as health care providers, health managers, health policymakers and health researchers) to make informed decisions about their own health, the health of others, and Canada's health system.³⁸

An info-structure is the combination of technological tools and information provided by patients and practitioners that form a base of knowledge which inform decisions made by all participants in the health care system. The ongoing development and use of this information structure will benefit the health system as a whole and provide an important set of tools to resolve wait time issues.

Each province is at a different place in the implementation of its information technology agenda, but there are visible common features developing:

- regionalization
- creation of electronic health records
- digitizing the process for collecting patient data in both hospital and non-hospital settings
- automation of physician offices and placing the patient at the centre of care.
- in some jurisdictions, ensuring that all physicians have computer systems that are compatible with the provincial electronic health record; and
- others concentrating on the establishment of registries and other overarching systems.

4.2 Health care professional scenario

In order to illustrate the importance of information technology and how it can play a role in improving wait times, Canada Health Infoway has described the scenario of Betty Smith³⁹ who, over the space of thirteen months, journeys from her first appointment with her family physician to the date of the surgery to address her hip pain. The scenario shows how, at each of the phases in Betty's care, information management and technology are critical to providing accurate and current details on Betty's status. It is not hard to imagine how Betty experiences her journey or to understand what doubts she may have with respect to the right information getting to the right person or place in the shortest time possible.

The same concerns exist for health care professionals involved in patient care. A family physician may see a patient, perhaps several times, adding notes at each visit to the hand-written and hand-filed patient chart in his/her neighbourhood office. Diagnostic tests are ordered and a receptionist makes appointments. The test results that are mailed or faxed back to the physician's office may be the only

³⁸ Health Canada, "Health Care System: Canada's Health Infostructure" found at http://www.hc-sc.gc.ca/hcs-sss/ehealth-esante/infostructure/index_e.html on March 27, 2006.

³⁹ Canada Health Infoway, *Addressing Wait Times with Information Technology*, p. 14-15.

indication that the patient did indeed go for the tests. Test results are manually recorded on the test requisition and sent by mail, courier, and sometimes by fax to the physician's office where they may linger in in-baskets or file folders until a physician has had a chance to review them and take further action.

Similarly, the physician's referral of the patient to a specialist will be booked by phone from one receptionist to another. The family physician may dictate or draft a letter that is typed and sent by mail or fax. The vast majority of physicians do not use email communication in their practice. Delays can and do occur; phone calls may not be made until the following morning or may not be returned for a day or two. The results of diagnostic tests or consultations can travel back to the family physician at a slow pace or can be lost or delayed along the way. As the patient engages with one or more specialists, the family physician may become disconnected entirely from the patient's care and receive the specialist's written report much later. Throughout this time the family physician is attending to others with unique needs and circumstances. The exchange of information from one person and place to another may be trusted to many people using many communication methods that are paper-based and susceptible to error or inefficiency.

4.3 Current issues in Information Technology

Hospital Care vs. Physician Offices

Across Canada, provinces are engaging in agreements and initiatives related to implementing technological solutions in the health care system. These efforts have addressed needs in both acute care and community care. Currently, the registries and databases that have been established for diagnostic images, pharmaceuticals and waiting lists are primarily available in acute care settings. However, physicians in their private practices also need to be connected to this system to enable the family or general physician to remain engaged in and contribute to specialist care.

Connectivity

Professionals in both acute care (usually in secondary and tertiary hospitals) and primary care settings need the ability to access health information regarding their patients. Provinces and territories together with Canada Health Infoway are attempting to address this need with the development and implementation of the electronic medical record (EMR). It must be noted that an electronic medical record is the record kept within a doctor's office that documents all tests ordered, results received, drugs prescribed, office visits and other individual information specific to that doctor. Developing this capacity simultaneously will guarantee that no data gap is created and that providers in the health care system will use patient information to add efficiency to continuums of care.

According to the report on Health Human Resources from Task Force Two, physicians treating a patient tend to use technology primarily for administrative rather than clinical functions.⁴⁰ The Canadian Medical Association (CMA) has suggested that while physician use of technology is higher

⁴⁰ Task Force Two (started in 2003) is a joint effort between governments and professional organizations dedicated to developing a Pan-Canadian strategy for Health Human Resources. This is a follow up to Task Force One (initiated in 1998 by the Canadian Medical Forum), which examined the issue of physician shortage in Canada.

than many might expect, EMR's are not used to full advantage in Canada.⁴¹ Only 14% of practising Canadian physicians are currently using EMR's and only 3% of these users rely on them exclusively for patient information. Patient records continue to exist predominantly on paper and it is suggested that this will continue until "all providers adopt interoperable data systems that communicate with, and contribute to, a regional EHR."⁴² The electronic health record (EHR) is a system-wide record of an individual's procedures, doctor visits, medical care that relate to all physician contacts, hospital stays, and other activities within the provincial health system.

Informed consent

The issue of informed consent for the collection and storage of patient information has to be addressed while the EHR develops. Advances in information management and technology allow doctors and patients to be more informed about the patient's health history, current treatments and progression of diseases or conditions. This also ensures that patients are able to obtain necessary information to make choices about their health care and self-care.

Ensuring both patient and physician have a complete set of data allows them to make fully informed decisions and choices regarding treatment of the patient's condition. With this increased knowledge and understanding a patient will be able to give his/her informed consent to treatment decisions or preventative measures suggested by their physician which in turn will have direct impact on their health outcomes.

Privacy

Health information privacy is an important issue in wait time management - one that involves identifiable health information. An electronic health info-structure supports the health information privacy legislation already in place across Canada (e.g. different rules for managing consent). The wait time management solution would provide a foundation to this info-structure, rather than reinventing the wheel.

4.4 Technology tools

The adoption of e-health systems is a high priority in all health care jurisdictions. For each jurisdiction the main question that needs to be addressed is: How do we expedite a province-wide e-health system? IT offers solutions that support the infrastructures of systems using IT tools as the piers. An inventory of some, but not all, essential tools follows:

Tele-health

Tele-health initiatives are a feature of the e-health⁴³ framework currently being implemented across Canada. Tele-health is defined as the delivery of health related services and information via

⁴¹ CMA Report

⁴² Task Force Two, p. 11.

⁴³ The Journal of Medical Internet Research has defined E-health as "an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the

telecommunications technologies.⁴⁴ Clinical uses of telehealth technologies refers to:

- transmission of medical images for diagnosis;
- groups or individuals exchanging health services or education live via videoconference;
- transmission of medical data for diagnosis or disease management;
- health advice by telephone.

Non-clinical uses of tele-health technologies include:

- distance education including continuing medical education, grand rounds, and patient education;
- administrative uses including meetings among telehealth networks, supervision, and presentations;
- research.

Electronic Medical Record (EMR)

As discussed above, the EMR currently exists in some computerized clinics and physician offices. These records are similar to the EHR but have a smaller scope defined by the physician's involvement with the patient. An EMR can help inform the EHR and can be linked to the EHR in order to provide more extensive information to the individual provider and patient.

Electronic Health Record (EHR)

One of the key tools for e-health implementation is the electronic health record. The EHR is designed to facilitate the sharing of data across the continuum of care, across health care delivery organizations and across geographies. This electronic file establishes a private and secure record of all episodic and historic care received within the system. The record is available anywhere, anytime to health care providers and patients in order to support access to care as required. An EHR is also an important means of reducing preventable medical errors by guaranteeing the practitioner has all the information available at the time of decision-making and increasing patient safety by providing quick access to this information.

In general and to summarize, the benefits of an EHR in the health system are:

- increased access to integrated patient information;
- reduced duplicate tests and prescriptions;
- reduced physician prescription call backs;
- reduced patient and provider travel costs;
- improved vaccine management;
- improved information management resulting in reduced costs.

Internet and related technologies. In a broader sense, the term characterizes not only a technical development, but also a state-of-mind, a way of thinking, an attitude, and a commitment for networked, global thinking, to improve health care locally, regionally, and worldwide by using information and communication technology.”

⁴⁴ Definition of tele-health obtained from Wikipedia: <http://en.wikipedia.org/wiki/Telehealth>

Electronic health records can play a significant role in reducing wait times. “In essence, an EHR will increase productivity through efficiencies and care coordination at a level that is difficult, if not impossible, to achieve without technology.”⁴⁵

Electronic health records are not used solely within a physician’s office. Hospitals can contribute to and use the information that is within EHR’s. However, as CMA has pointed out: “only 25 percent of Canada’s hospitals have been able to afford electronic provider order entry for pharmaceuticals, only 15 percent currently have electronic systems for managing diagnostic images, and only 36 percent currently use electronic records.”⁴⁶

Registries

Increasingly health care providers are moving from paper-based to electronic media to store pertinent information on patients in databases that are constructed to allow in-depth analyses of the information they contain. These databases are known as wait list registries⁴⁷ and provide valuable information to both patients and providers. This patient data will help determine the urgency and other pertinent details related to the patient’s care. A wait list registry is essentially a list of patients waiting for a specific medical procedure or intervention. These types of lists have generally been paper based but this has limited the ability of care providers to analyze or compare information that has been collected. “Traditional paper-based recording and storage systems have long since ceased to support the health service in an efficient and effective manner. As a result, many general practice surgeries and hospitals now have some form of personal care record that can be shared internally.”⁴⁸ The ability to share information both internally *and* externally is an important advancement in technology.

Wait Time Websites⁴⁹

Many provinces, in an effort to provide more information to patients and providers have established wait time websites.⁵⁰ These web pages provide varying levels of detail on the length of wait lists for different surgeries and procedures ranging from cardiac surgery to cancer radiotherapy.

Some of the wait time websites offer a wider range of information, including the average wait time for specific surgeries and procedures on a province-wide basis. Some sites provide outcomes data on individual surgeons that allows patients to compare their particular physician to others in the provinces. This information makes it possible for a patient to request another location or another physician in order to shorten their waiting time.

⁴⁵ Dr. Mark Dermer, Dr. Bob Burns and Catarina Versaavel, *End User Acceptance Strategy*. February 1, 2006 presentation to the Canadian Medical Association, Ottawa, Ontario.

⁴⁶ TkMC, 2005

⁴⁷ Global Tiger Systems Solutions Inc., *Surgical Waiting List Registries and Waiting List Initiatives in Canada*. Prepared for Acute Care and Technology Unit, Quality Care, Technology and Pharmaceuticals Division, Health Care Policy and Communications Branch, Health Canada, November 18, 2005, p. 3.

⁴⁸ Department of Health, *Putting People at the Heart of Public Services: The NHS Improvement Plan*, (Government of England: London, 2004), p. 68.

⁴⁹ National Health Council, *Background on Wait Times* (2005). Appendix D: Provincial Wait Time Websites

⁵⁰ Refer to Appendix D: Provincial Wait Time Websites

4.5 Canada Health Infoway

Canada Health Infoway Inc. is an independent not-for-profit organization that works in partnership with the public sector. Its role is to invest in, implement and reuse compatible health information systems that support a safer, more efficient health care system. Members include Canada's 14 federal, provinces and territories and the board consists of all the Ministers of Health. To date Infoway Inc has funded over one hundred projects that have either been completed or are underway in all jurisdictions. These activities are "delivering electronic health solutions to Canadians – solutions that bring tangible value to patients, providers and the health care system."⁵¹

To date Infoway has received \$1.2 billion for the development of health information systems including EHR's, tele-health and public health surveillance systems. As of March 31, 2005, Infoway had approved \$321 million in project investments. It expects to approve an additional \$325 million in 2005-2006, which would result in an estimated cumulative \$646 million in approved projects.

Infoway's ongoing mission is the development of an e-health info-structure across Canada. This will make patient information more readily accessible and put it in the right place at the right time for the benefit of patients and appropriate professionals.

Canada Health Infoway Analysis on Wait Times Solutions

In order to fully understand the implications of implementing a Canada wide system for efficient management of wait times, I asked Canada Health Infoway to conduct an analysis of the current state of technology in the Canadian health care system. Their analysis is included with this report (Report 2: Canada Health Infoway: *Addressing Wait Times with Information Technology*).

Wait time initiatives in Canada have varied from web-based reporting of wait times in selected surgical and diagnostic procedures to more focused investments that will increase capacity and redesign health system processes. Information and communication technologies have demonstrated their value in many of Infoway's efforts to date and will increasingly become crucial to supporting clinicians in providing timely and equitable access to quality health care for Canadians.

The use of information and communication technologies will result in the following benefits in the areas of access, quality and productivity:

Access

- **support timely delivery of care** - solutions to improve referral and scheduling processes and overall case management will help providers decrease the overall time between identification of need and treatment;
- **support equitable distribution of care** - solutions for prioritization of resource usage will help ensure that care is delivered appropriately on the basis of need.

⁵¹ Canada Health Infoway, *Canada Health Infoway Inc. Corporate Business Plan 2005-2006, Building on Our Successes*. Toronto: Canada Health Infoway Inc., 2005.

Quality

- **improve appropriateness of care** - standardized assessment and wait time prioritization will help providers ensure that the wait time is appropriate for the patient;
- **improve effectiveness of care** - more timely access to physicians, specialists, diagnostic tests, surgical procedures, as well as after care services, will provide for improved health outcomes and reduced pressure on the system.

Productivity

- **improve provider productivity** - information technology will impact provider productivity in many ways, from ease of access to information to improved efficiencies (e.g. reduced call backs, reduced duplicate tests);
- **more efficient resource use** - solutions for scheduling will help managers optimize the use of scarce human and physical resources;
- **improve coordination of care** - case management will allow a virtual team of providers to more easily coordinate the successful completion of a patient's treatment plan

In order to better manage wait times an investment in referral management, scheduling, case management, wait time monitoring and reporting systems, location registry, physician electronic medical records and patient portal technologies is needed.

Technology costs will continue to increase over time. Delays in the implementation of health care IT solutions must be avoided. Future IT systems will build on existing work Infoway or government funded projects that have already taken place across Canada. The estimated time frame for implementation of the proposed systems associated with wait time management is three to six years. I propose that federal, provincial and territorial governments continue to work on both pan-Canadian and provincial information technology and management initiatives in order to take full advantage of the benefits that will accrue from this technology. Failing to do so will put patient care and our health care systems at risk.

4.6 Conclusion

An electronic health record infrastructure is a fundamental tool for the future development of wait time management tools. The wait time systems under development within the provinces and territories mark the beginning but could benefit from the functionality that Infoway is proposing. Canada Health Infoway's analysis shows the way to achieve a Canada-wide, interoperable electronic health record by 2009. In addition, the recommended wait time management technology can be implemented alongside the EHR so that when the wait time management systems are ready to come online, data will be available to support them. While it takes time for the adoption of technology solutions both systemically and by the end users, all jurisdictions need to push forward to ensure that delays are minimized. The sooner this technology is widely in use, the sooner we will see better management of wait lists and patient care in general.

**Chapter 4: Information Technology (IT)
Recommendations**

8. That the federal, provincial and territorial governments accelerate the pace of pan-Canadian health information technology through Canada Health Infoway;
9. That Canada Health Infoway:
 - Develop wait time tools as proposed;
 - Continue the development of the Electronic Health Record with a plan and timeline supported by FPT governments.
10. That the development of IT health information systems in Canada be accompanied by public education to assure Canadians that privacy of information is secured;

Chapter 5: Professional Roles and Responsibilities

In the foregoing chapters I have made a number of recommendations on how to substantially improve wait times in health care systems. The recommendations so far have fallen into two major categories. First is the research that will help us to understand the effect of benchmarks and their utility in health care systems. Health systems research will permit us to continuously improve our ability to move patients smoothly through the health care system. Second are the management techniques and innovations, including information technology, that will sort out lingering system problems that we have inherited from generations of clinical and managerial predecessors.

I believe that the problem of wait times is a problem not just of “being made to wait” or “making someone wait”. It is a problem of the focus of the system and the processes and machinery that support it. Over many years our health care systems have been pushed and pulled to accommodate many different goals, interests and needs of professionals and administrators. The issues associated with wait times can be addressed if we are able to refocus the system to put the patient at the centre of our attention and problem solving.

The issue of wait times is a systemic problem that requires a systemic solution. Moreover, specific measures that make up this solution must be supported by a general cultural shift within the health system and among professionals. Without a movement that changes attitudes, assumptions, and patterns of behaviour of the leaders, managers and providers of care, concrete measures are unlikely to succeed.

The discussion in this chapter will centre around the role and responsibility of health care professionals, illustrated largely through a discussion of the roles of physicians in our current health care systems. Much of what I will say reflects my own experience in medicine, my experience of working in and later leading health care delivery institutions of various sizes and more recently my discussions with fellow administrators, physicians and provincial colleagues.

With respect to the issue of wait times it is important to note that physicians, regardless of their area of practice, represent only one set of many different health care professionals involved in the totality of health care. Other groups, including but not limited to nurses, health care aides, technicians of many disciplines, administrators and managers, increasingly social workers and therapists, all play important roles in the continuum of modern health care. These professionals organize and deliver care across facilities, in and out of acute care and in the home, in private offices and in community settings. All of us would be hard pressed to decide which member of the health care team could be eliminated without the team and patient losing out in some way.

5.1 The unique role of physicians in health care systems

Canadians for the most part feel that as patients, or as the family or friends of patients, they can be justifiably grateful to physicians and surgeons, family practice doctors, specialists and medical researchers, for the commitment and caring that these professionals demonstrate to their patients. Many Canadians will likely be able to recount an instance in which he or she, a child or parent,

received a physician's careful attention, guidance through a medical problem or the maze of medical infrastructure, to benefit from an intervention or support that our health system affords Canadians. I believe that most Canadians feel this way, as do I. I have had the opportunity to witness this sentiment expressed frequently and I share with my colleagues the pride of esteem with which physicians are held in Canada.

All health care professionals have roles and responsibilities that are unique to their own profession. What makes physicians and surgeons unique, and therefore important to address directly, is the degree of influence that they are able to exercise over health care systems. This is either as a consequence of their ability to control systems of care (processes, organization and efficiencies) or to shape them through collective strength, individual participation, and cooperation or lack thereof. It is also a consequence of their relative independence. Other professionals or care providers are employees of the system or contracted to the system while physicians are most often self-employed, may work in an entrepreneurial model and are most often paid on a fee-for-service basis.

Physicians as the "Gatekeepers"

Physicians are known as the "gatekeepers" of patients and patient care. This is a feature both of the traditions of medical care prior to the development of large health care systems and of institutional processes and administration that have traditionally centered on the role of physicians as the decision-maker. As gatekeepers, physicians have the ability to direct patient care and advance a patient to the next step of care. It is the physician who determines whether diagnostics are to be undertaken, prescriptions provided, medical and surgical interventions performed and so forth. Additionally physicians have autonomy as independent professionals to assign their time commitments and organize their practices.

Most physicians receive public money according to a schedule negotiated by provincial governments with provincial medical associations. Although there has been some change in the employment status profile of physicians over the last several decades, with physician's increasingly choosing salary-based roles (in a parallel stream in which funding allocations accrue to regional health authorities, hospitals or clinics), the fee-for-service arrangement remains predominant. Additionally, physician institutions, medical associations and specialist societies continue to reflect the autonomous organization of physician functions. Medical associations often reflect the values of independent business and clinical autonomy in exclusive relationship with the patients. Most physicians do not "work for the hospital". Most do not have a contractual or business arrangement in place with that institution that describes the responsibility of the physician and the facility. The relationship of the physician to the institution is defined typically by medical staff by-laws, which reflect the "rules of engagement" for physician functions within an RHA or hospital. There is seldom an agreement that binds practitioners to a prescribed level of service of volume, quality or efficiency. There is for most physicians and specialists in private practice no obligation to participate in change processes at the level of the facility or to cooperate with the procedural changes that others have adopted.

Because of their autonomy and their role in directing patient care, physicians are in a powerful position to support or resist system change. It is imperative that physicians are engaged effectively in system transformations that will support improved patient access to care.

In many provinces and health care institutions physicians are already contributing to great change processes with the issue of wait times central to their efforts. There is not a province that has made substantial progress on wait times without clinical leaders championing improved standards of care, greater efficiencies, and meaningful involvement of physicians that care. These clinical leaders cannot, however, accomplish these changes on their own, and cannot ensure that the efforts will endure without systemic supports around them. It has been my experience that the forces of change are seldom as strong as the forces against change. All participants in the health care system have a duty to promote system change that contributes to quality care.

5.2 Physician institutions

Physician organizations and professional regulatory bodies frequently provide representation in health system change processes by participating in local, regional, provincial and national discussions. Medical associations represent the goals, desires and interests of their physician membership. Provincial institutions such as Colleges of Physicians and Surgeons, which exist as a result of provincial legislation, protect the interest of the public with respect to licensing, medical practice standard setting and discipline. Colleges seldom participate in proactive consultation associated with system change and frequently find themselves exercising their legislated roles in reaction to system change that has been undertaken without their advice.

There also exists a community of professional interest, associated with the education and training of physicians, from undergraduate to specialty and sub-specialty education. This community of interest is intertwined with academic medical centres and a cadre of clinical researchers, health scientists and teachers. Medical educators and researchers bring a different perspective to the design and analysis of health care systems.

The system changes that I am proposing have the potential to improve efficiency throughout the health care system. This is especially true as it relates to the recommendations of the preceding chapter regarding the importance and impact of information technology in the health care system. The planning of the changes, the process that supports the changes and ensures that they address the needs that exist, should rely on advice from the medical community. Not only is it necessary and desirable to hear from the associations directed by physicians at large, it is necessary to hear from physician communities that are responsible for the professional conduct of physicians and their education.

5.3 Professional standards to support change

The words “system transformation” are purposefully expansive. The changes proposed throughout this final report are not only necessary but must be implemented urgently and pervasively. These changes will require careful planning, careful execution and the cooperation and participation of many health care professionals including but not limited to: physicians, nurses, statisticians, administrators and managers. Success will depend on ensuring that clinicians adopt new roles and responsibilities. The issue of wait times is urgent and the urgency requires that new standards of professional behaviour be developed and sustained in the long term. Expected changes in practice patterns will

require the development and implementation of standards of professional conduct to be monitored and promulgated through Colleges of Physicians and Surgeons.

5.4 Educational efforts to perpetuate change

Canada's capacity for medical education is tested by many new factors that emerge on a daily basis. New demands include new conditions, changing demographics, new technology and the new expectations of students. As well public and political expectations are changing and are reflected through the media, often in a negative way. All medical schools in Canada have recently expanded medical class size to increase the number of graduating students and concomitant family physician and specialty training programs. As a result, health care systems in Canada, including educational infrastructure, must ensure that medical education incorporates emphasis on the program goals and societal values that accompany this requirement. Timely access, efficient, high quality care and fairness must be intrinsic in our delivery systems. Physicians graduating from Canadian medical schools should expect and respect the system-wide standards that Canadians support and which leaders, practitioners and employees of their health care systems can be expected to implement.

5.5 Issues of competency

The physician-patient relationship is important to physicians and patients alike. For many it is paramount in their experience of health care – an important foundation for understanding and trust.

There is already considerable variation in the physician patient relationship. Anaesthetists typically see patients only in pre-operative and operative settings and radiologists are normally service-based working either in hospital or clinic settings. In many specialty programs such as cancer care, cardiac surgery and neurosurgery physician assignments are made to patients at the point of system entry. This is referred to as service-based care. In these clinics physicians work as equal team members and provide services collaboratively.

It may be that the implementation of “service based care” and “first available slot” will result in a patient receiving surgery from a surgeon that he/she sees only in the context of that surgery. Patients need to have the confidence that whatever physician provides their care is of unquestionable competency. It is therefore incumbent on medical schools that Colleges of Physicians and Surgeons in each province, Regional Health Authorities and hospitals ensure that standards of medical education, practice and professional oversight are sufficient to guarantee that care will be undertaken by capable and competent practitioners in every instance in which care is provided.

5.6 Definition of roles

The issue of definition of professional roles has been addressed in Chapter 3. It remains in this section of the report only to emphasize that the development of professional scopes of practice and the definition of skills and training required to assume professional responsibility requires a long and exacting effort. Professional roles and all of their accoutrements: education, licensing, regulation,

competency testing, labour regulations, pay schedules and transferability, contribute to organization and to patient safety. At the same time they have the ability to create turf wars and professional stovepipes that can impede change or stifle innovation.

One means of ensuring enhanced access is to ensure that all professionals are functioning to their full scope of practice. This would ultimately free up resources at several levels that could focus on the issues of wait list management through volume increases and innovation.

5.7 Conclusion

Many of the changes that are proposed in this report have the potential to dramatically change the way we as Canadians and patients experience medical care. The recommendations not only have the ability to reduce the time that patients can expect to wait for medically necessary care but also the relationships experienced throughout the process.

Chapter 5: Professional Roles and Responsibilities Recommendations

11. That FPT governments develop a broad base for receiving advice from medical communities with respect to change in the health system and long term planning. The Canadian Medical Forum can be asked to assume this role nationally, with provinces developing similar capacities locally to achieve balanced influence when medical input are deemed important;
12. That provincial Colleges of Physicians and Surgeons establish professional and ethical standards and the means to monitor professional practice with respect to physician management of wait times in provincial health care systems. The Federation of Regulatory Authorities of Canada should coordinate this effort;
13. That Faculties of Medicine of Canadian universities develop curricula that supports changing health care systems and changing expectations regarding the competencies that physicians will require to participate in these systems led by The Association of Medical Faculties of Canada;
14. That FPT work on Health Human Resources initiatives focus on re-defining professional clinical roles to enable health care professionals to work at their full potential and to offer innovations in health care, which are economical and sustainable.

Chapter 6: Additional Issues

Early in the discussion regarding wait times in Canada it became clear that there were several specific issues that required attention and that were not formally a part of my mandate. Each issue has implications for understanding wait times and each issue has significance for health care systems in general. I am addressing these issues as a part of this final report both to recognize the work that others have done on these subjects and also to encourage an FPT discussion such that these elements of analysis can be added to wait times discussions in Canada. These issues are:

- wait times for children
- surge capacity
- health human resources
- gender-based analysis
- Cinderella diseases
- other provincial priorities

A brief discussion of each of these items follows. Where specific work has been undertaken on the subject a report is appended. Various individuals and groups from across the country continue to address these issues. I want to thank them for their contribution to this report.

6.1 Children's wait times

Children's conditions were not identified in the First Ministers' *10-Year Action Plan to Strengthen Health Care*. Although it might be argued that the five priority areas identified by First Ministers do not explicitly exclude children and their conditions, it is widely accepted that the five areas address conditions most often associated with adults.

Experience shows that many Canadians will automatically assume that children receive care on a priority basis. While this may reflect our common sense or shared values, the fact is that children's hospitals and children's health care generally do not fare better than adult care with respect to financial resources. Additionally, the advocates for children's care are often parents whose time and attention is spent caring for the child. Addressing wait times for children's clinical and surgical interventions is therefore a moral responsibility - a trust responsibility - that needs to be shared by society at large. This report is an opportunity to ensure that Canadians understand that need.

In the fall of 2005, I discussed with the National Child and Youth Health Coalition (NCYHC) research they were conducting on access targets for children's surgical procedures. The decision that resulted was that NCYHC would continue to develop access targets for key conditions using evidence available at the time.

Fortunately the work of NCYHC was sufficiently advanced that it was possible to proceed quickly to a broad consultation amongst clinical/surgical directors and managers of children's hospitals and health centers in Canada. Access targets were developed using Ontario's paediatric wait time

definitions as a model and as a basis for discussion and consensus. NCYHC's report summary and approximately 350 access targets in nine subspecialties are appended.⁵²

I would like to comment on this subject to increase the possibility that children's wait times will join the mainstream of the wait times discussion in Canada and because of that enjoy the same success.

Delays in scheduled care, or long waits for needed care, can present problems for adults and children alike. There is however a significant difference for children in that their growth and development is rapid. For some conditions the opportunity to intervene clinically or surgically is very brief – the window opens and closes quickly. To miss that opportunity is to miss getting the most from the procedure over time. Related to this is of course the social, educational and psychological affects associated with illness, hospitalization and the inability of the child to participate in the real work of growing up. The failure to progress with their cohort can affect a child's life for a long time.

I am hopeful that having addressed this issue FPT governments will draw the issue of children's wait times into their ongoing discussions. I commend the work of the NCYHC to your attention and trust that it will provide a good basis for discussion between provincial governments and their Children's Health Centres.

6.2 Surge capacity

The issue of "surge capacity" has arisen frequently throughout the wait time discussions. All provinces plan for basic health care services for their citizens, covering the spectrum from primary health care services to, tertiary services. There are however times during which the local system will experience a surge of need or demand that will outstrip its capacity to manage pressing needs in a timely way. In situations such as these, there is the desire, and arguably a necessity, to establish a mechanism through which additional unused capacity, outside of the local region or outside of the province, can be utilized. Sometimes this surge capacity exists and sometimes it does not.

The need to address surge capacity is not new and it does not result solely from our current concern about wait times. Surge capacity has been an issue in Canada for many years. There have always been times or circumstances in which hospitals, regions or provinces have called on one another for help to address volumes of care or specific types of care.

Our ability to anticipate and quantify planned and unplanned health care need will need to be developed. My intention here is to help define the terms and to illuminate the potential issues around surge capacity so that further study and/or collaboration with respect to this issue can advance.

The term "surge capacity" has not appeared frequently in the health care vocabulary in Canada until the severe acute respiratory syndrome (SARS) event in Toronto, Ontario in 2001. Subsequent to the Report of the National Advisory Committee on SARS and Public Health (2003)⁵³ and the formation of

⁵² See Report 3: National Child and Youth Health Coalition: *National Paediatric Surgical Wait Times Strategy: Access Targets*

⁵³ Dr. David Naylor, Chair, *Learning from SARS: Renewal of Public Health*. A Report of the National Advisory Committee on SARS and Public Health. (Ottawa: October, 2003).

the Public Health Agency of Canada (PHAC), the term has become more commonplace, largely used to describe the capacity for frontline responses to emergencies, including the assembly of special teams from multiple program areas or jurisdictions. The term has also been used to describe the backup or back filling required for experts and clinicians who work on such activities as laboratory testing, data management and analysis, policy development, and emergency responsiveness and management.

Consider the hypothetical circumstance of a surge and an extraordinary volume of case types requiring access to the health care system. This could include a natural or manmade disaster, such as a storm or refinery explosion, respectively. Less dramatic circumstances might include an extra large number of cases moving through the system as a consequence of an unplanned event, e.g. flu season or multiple traumas during a prolonged period of inclement weather conditions. Surges can also occur when human resources are not adequately available. One of three surgeons retiring in a practice setting could well cause an increase in wait times until a replacement is recruited.

Contrary to unplanned events, surges in activity and demand may be a consequence of planned events, such as the need to increase the supply of services (such as cataract surgery to clear up backlogs of scheduled patients waiting for long periods). The urgency of a planned disturbance in activity level, or the perception of it, may be influenced by a wide variety of factors such as: clinical, economic, and political, to name but a few.

An additional circumstance potentially exists in insufficient volumes of cases in a particular healthcare jurisdiction, prompting the concentration of care for such cases geographically and in juxtaposition to a region with greater capacity and expertise. This volume/quality relationship is well researched, particularly in high-tech and high-intensity services. In short, the more you do, the better you get at it. This stretches the definition and notion of surge capacity. Concentrating volumes of services of any type requires management and processes for the specialized centres, in order for the specialized capacity to be met.

There may be other imaginable surges which could include a “rush” for services brought on by the public, as a consequence of fear or hysteria, such as a surge of people seeking vaccination, or indeed any scenario when individuals in a planned or unplanned fashion place an unusual demand on the system for access. In every case, there are two central challenges:

- dealing with the surge in activity, and
- dealing with its short and long-term impact on the balance of the health care system.

This of course has a direct and measurable impact on provision of scheduled services and hence, waiting times.

Table 1 attempts to categorize surge into two broad categories of unplanned and planned service components.

Table 6.1: Surge Capacity

Scope		Nature	Scaled Accountability
Unplanned Case Volumes	1.1 Disaster	Natural	Local; Provincial; environmental services; PHAC
		Man-Made	Local; Provincial; environmental services; PHAC; military services
	1.2 Non-Disaster (Converts to 1.1 depends on magnitude/intensity)	Infectious	Local and provincial health labs ± Public Health Laboratory (Winnipeg)
		Traumatic	Local; Provincial; multi-provincial
		Toxic	Local; Provincial; multi-provincial; environmental
		Public hysteria	Local, provincial ± PHAC
Planned Case Volumes	Provincial	Case backlogs	Local & Intra-provincial ± multi-provincial
	Multi-provincial (might assume by agreement)	Specialized interprovincial referral centres	Provincial/Multi-Provincial

For the purposes of this report, the following operational definition is offered: Surge capacity is the responsiveness of the health care system to absorb both planned and unplanned requirements of access. Whatever the cause of the surge, the issues and challenges of coping with additional requirements for access have implications for both patients and caregivers, as well as those affected as a consequence of the collateral impact of the surge.

Canadians have experience with organizing health services to address a need where volume is insufficient to warrant a specialized program of care. Western Canada’s Child Cardiac Care Consortium was established to gain the advantages of higher volumes and collaborative practice between four western provinces and has been highly successful in terms of both clinical management and clinical outcomes.

Concentrating expertise and capacity such as this requires special and defined service agreements. Capacity to deal with planned activities and high-tech services stresses the system in different ways than does providing capacity for unplanned services, such as trauma. For a specialized referral centre to cope with volume, capacity must be built into the system in advance.

Examples of existing concentrated services in the provinces are contained in the following tables: Intraprovincial (Table 6.2) and interprovincial services (Table 6.3).

Table 6. 2: Concentrated Intra-provincial Services*

Kidney Transplantation
Trauma Services
Neuro-vascular and Cardiovascular Interventional Services
Selected Cancer Services (e.g. Radiotherapy)

*representative, not comprehensive

Table 6.3: Concentrated Inter-provincial Services*

Heart and Heart/Lung Transplantation
Paediatric Cardiovascular Surgery
Bone Marrow Transplantation
Extracorporeal Membrane Oxygenation for Low Birth Weight Infants
Hyperbaric oxygenation for anaerobic sepsis, carbon monoxide poisoning, and diving injuries

*representative, not comprehensive

The criteria that is best applied to the development of concentrated out-of-province services includes a combination of 1) a supply for high-tech or high-intensity services, with 2) some combination of demand for extremely expensive infrastructure and/or 3) highly qualified personnel. The benefit associated with concentration of provincial services is that there can be concentration of infra-structural costs, as well as qualified expertise in personnel, providing the additional benefits of an environment for better training and research. The downside of concentrating services is the impact on patients having to be moved, families separated from them or being required to travel.

Being responsible for service delivery requires provinces, through their health care regions and facilities, to provide access for both scheduled and emergency services. Inter-provincial agreements are essential when services are shared or concentrated.

In order to concentrate tertiary and quaternary referrals, there needs to be a sound database from which to determine the demand for services. With information derived from such a knowledge base, concentrated services would need to be organized in a fashion so as to achieve balance between the service rate and the arrival rate, or otherwise line-ups form, either at the specialized or the referral sites, or both. Simulation modelling is useful to accomplish the supply and demand match. The fuel for simulation modeling is data available through regional health authorities and the CIHI.

Census and demographic information required for long-term planning come from Statistics Canada. Linkage of regional data and a variety of health-related survey data and instruments from Statistics Canada offers very active opportunities for new insights on population health and interventions.

Different kinds of surge capacity required across Canada require different approaches:

- For informed thinking and strategies in unplanned surge, we can learn from existing emergency and disaster demand approaches, and to better coordination and integration of these services.

- For backlogs, attention must be given to adding interim and additional supply, while paying attention to creating and not altering supply and demand match necessary for steady-state conditions.
- In the case of specialized referral services, planned volume must be rationalized and form the basis of service agreements, with the receiving centres adding sufficient capacity so as not to compromise its regular activities and service volumes.
- For unplanned surges, standby capacity is a theoretical but costly and often impractical consideration. Multipurpose training offers some ability to cope. But, for both these surges and planned increases in activity much more use must be made of plans that incorporate industrial management techniques

I urge federal, provincial and territorial governments to consider the potential of arrangements planned to address issues of surge capacity. There will be times and circumstances for which need and demand cannot be safely accommodated in a timely way and close to home at the same time. Our provincial health care services have developed different bodies of experience and expertise to address the needs of different populations with different health issues. This diverse capacity can be captured for the benefit of all Canadians.

Canadians would be well served by further investigation of this potential as a means to address planned or unplanned volumes of needs. All regions of Canada continue to experience shifts in need and capacity that are not yet managed. The ability for provinces to look across the landscape of unmet need and to collaborate proactively will create a network of health systems that is more fail-safe. The “natural” regions of Canada (West, Atlantic, Quebec and Ontario) would be wise collaborate to study their needs for clinical and/or surgical capacity and develop innovations to address as yet unmet need. The federal government could support this effort by investing in provincial efforts to define needs and the surge capacity that is required to address them. This initiative would lend itself easily to four regional pilot projects. There is of course a need for collaboration amongst the provinces in one region but it would benefit Canadians as well if these four regions could take collaboration to the next level and plan for inter-regional synergy. While Canada’s constitution provides for provinces to manage health care delivery systems within their own boundaries, it does not prevent provinces from together creating complementary capacities.

6.3 Health human resources

It is often said that people are the greatest asset of the Canadian health care system. The “people” in this case is an enormous volume of professionals, paraprofessionals, managers and policy makers who work in diverse environments and in complex systems. However regular reports show that the public and professionals are concerned about the sustainability of the health care workforce in Canada. Shortages of anaesthesiologists, family doctors, psychiatrists, nurses and other health care professionals cause concern for the public alongside sometimes significant delays in treatment.

Like other issues addressed in this chapter of my final report, Health Human Resources (HHR) is not one of the issues that I was specifically mandated to address. The issues of HHR are significant. They relate to wait times and more. The scope of HHR management includes changes in the way health professions are perceived, the ability to recruit, new educational challenges, distribution, distribution

according to need, safety at the worksite and of course volume - the numbers of health care providers on the ground and their availability to work when we need them. The list is long.

It is important that health departments, health regions and the public are aware of the initiatives that are being undertaken across the country to address some of the issues of health human resources. Officials in Health Canada who are assigned to this task and who work with provinces to accomplish their mandate have prepared a report to describe current national collaborative initiatives. The report on the Pan-Canadian Health Human Resource Strategy can be found appended to this report.⁵⁴

6.4 Gender-based analysis

In health care, as in many other fields of social importance, our efforts to progress and do good work sometimes foreshorten the planning period. We find out in due course that the plans that we made and the solutions that we contrived have overlooked important considerations, the understanding of which would have made for a better plan, a better program or service.

This argument applies well to the policy tool of gender-based analysis (GBA). For a very long time we planned programs and developed care plans with no consideration of the difference between men and women, boys and girls. It is only really over the last couple of decades that consideration has been given to these issues and that our planning, evaluation and care processes have been urged to look at and understand these differences and their implications for health care systems and patient care.

The relevance of gender-based analysis is as important to the issues of wait times as it is to other issues of health care. Failure to understand differential outcomes on population groups is a failure to do the work well.

Gender-based analysis is more than counting the number of women and men, boys or girls that have received service to make sure that the number is about the same. It is about getting under the numbers, before and after programs are planned and implemented, to understand the effect, both of sex and social conditions, that make unanalysed programs and unanalysed care sometimes miss the mark. GBA is an area of work that helps us to ensure that appropriate care of high quality is available to all men and women, boys and girls.

The processes to develop benchmarks, access targets and indicators related to wait times have been concerned primarily with the issues of how to increase the efficiency and effectiveness of the health care system to meet these goals. What has not been addressed in these discussions and research activities is the differential effect that disease, or indeed waiting for care, has on men and women.

In order to include this discussion in the final report, a partnership was struck with the Women and Health Care Reform Group who have agreed to allow their full report on the different impacts of wait times experienced by each gender to be appended. I hope that in this way Canadians can have a better understanding of gender-based analysis in a broad sense and how it can change the way in which

⁵⁴ See Report 4: Pan-Canadian Health Human Resource Strategy

issues in the health care system are examined. You will find the report of the Women and Health Care Reform Group in the appended reports.⁵⁵

6.5 Cinderella diseases

The term “Cinderella disease” has emerged in Canada around the issue of wait times. The term is an intuitive one and applies to the diseases that were not recognized, or “priorized” in the five selected areas of concern for which benchmarks were to be developed. “Cinderella diseases” are the ones that *did not get invited to the ball*. Unlike the “big five” –(joint replacement, cardiac, cancer, sight restoration and diagnostic imaging) these conditions and diseases, though important, have not made it into the first “cut”. The fear is, and the danger is, that the five conditions that figured prominently in FMM agreements will starve out all others for attention, resources and technology, leaving Cinderella diseases behind, in the shadows, at least temporarily if not permanently. This concern has been raised both by the public and by health care professionals in an Ipsos Reid poll undertaken in fall of 2005 and which states that “2 in 3 (Canadians) are concerned that meeting the wait time benchmarks in the five priority areas will come at the expense of other health care services.”⁵⁶

I need to caution that in the daily business of health care a possibility always exists that either a real need is present or there is the perception of a need. Often there are claims, some correct, that insufficient attention is being paid to one condition or another, or that a particular condition could be treated more effectively if only another service, drug, facility were available. This is the reality that has caused health care systems in provinces to look to evidence to identify what the priorities are or should be, what interventions are actually effective and which are not, what organized programs for a small population or for a large population can achieve the most benefit to individuals and society. We look to evidence to help clinicians and managers to make defensible decisions.

However the concern regarding “Cinderella diseases” is well taken. It is not appropriate for our health care systems to be so focused on limited areas that we neglect others. While it is important to dedicate resources to shorten wait times for procedures and interventions that are currently experiencing worrisome waits, it is also important to ensure that other diseases and conditions do not become the next areas to see wait times increase. Care must be taken to transform the system so that the efficiencies are experienced *across* our health care systems and not just within the five areas in which benchmarks have been set. Success for one area should not come at the expense of another.

The ongoing operational research (discussed in Chapter 2) that is being undertaken by CIHR would study the effect that benchmarks in specific areas have on other areas of the system. This research information can be used to influence and inform benchmarking and research processes.

⁵⁵ See Report 5: Women and Health Care Reform Group: *Gender Based Analysis and Wait Times Report: New Questions, New Knowledge*

⁵⁶ Ipsos Reid, *Canadian Views on Wait Time Benchmarks and Care Guarantees*. Presentation to the Canadian Medical Association, October 6, 2005.

6.6 Other Provincial Priorities

Canadians also need to be aware that the issue of wait times is important to different provinces in different ways. Provinces, regional health authorities and facilities are learning from one another about better business practices, improved use of technology and information systems. That learning will set new standards for efficiencies, appropriate wait times and satisfactory outcomes.

But apart from the forward-thinking work that provinces are doing with respect to wait times, each province has a unique set of program priorities that may not be affected by the wait time work at all. Many of these priorities will be identified annually in the provincial Speech from the Throne and then funded in provincial budgets. They range from intervention programs (crystal meth intervention might be a good example) to programs designed to address chronic conditions at various stages of their progress (diabetes would be a good example of a long term initiative). Provinces in their own health care systems need to strike the right balance between the issues that draw public attention nationally and the issues that occupy the hearts and minds of citizens within the cities and towns of the provinces. The work performed by health care decision-makers presents unique challenges.

6.7 Conclusion

Although not expressly identified in my mandate I am hopeful that these comments regarding additional issues will bring clarity or understanding to several issues that will remain with us as we forge ahead to address wait times in Canada.

Chapter 6: Additional Issues Recommendations

15. That provincial and territorial governments give consideration to the access targets developed by the National Youth and Child Health Coalition and consult as required with clinical leaders in children's health care, in order to consider their implementation. Further, that the conditions affecting children be included alongside adult-related conditions at the outset of future benchmarking processes to ensure that children receive equitable attention to their time-sensitive needs;
16. That FPT governments mandate an expert group to investigate the need and potential for surge capacity through the development of regional centres of excellence;
17. That ongoing research related to wait times adopt a broad approach to gender-based analysis in order to ensure that the issues of gender are considered thoroughly.

Chapter 7: Public Education

Canada's publicly funded health care system is of paramount importance to all Canadians. It has become clear to me throughout this process, that if we are to undergo a system transformation that will put the patient at the focus of health care services federal, provincial and territorial governments must engage Canadians in a substantial and continuing way. This will involve educating Canadians about their health care systems and how they work.

Many of my recommendations propose significant system change that will affect how health care systems organize themselves, how they manage their business and utilize modern means of providing care, and how patients relate to care providers. It is only through public engagement, increasing awareness of how current systems work and how the changes we propose can improve outcomes, that Canadians can be expected to support the change process.

A public engagement and education strategy must be long-term and far-reaching. It needs to consist of information about terminology (e.g. wait times, benchmarks) best business and industrial practices and innovations. It needs to include information on how the system works, what care is appropriate and what can reasonably be expected from the health care system as a whole. For example waiting before surgery may be appropriate in instances where a patient must improve his/her health status to ensure the success of a procedure or, as mentioned in an earlier chapter, to make personal arrangements either before or following surgery. This is just one of many messages that need to be communicated to the public and the media. Federal, provincial and territorial governments as well as professional organizations should be encouraged to collaborate in an effort to convey common messages to Canadians.

7.1 The need for a public education strategy

We have known for a long time that public support for Canada's health care system is dependent upon the belief that the system will be there when Canadians need it. The single-most compelling reason for initiating a national public education strategy for wait times is to restore confidence in the system's ability to provide quality care in a timely manner. The perception that long wait times are pervasive and that little can, is, or has been done to improve them, has the potential to further erode Canadians' confidence. The Canadian public must be educated not only on current progress in reducing wait times but also of the system transformations before and as they occur. The changes must be seen as solutions and education can play an important role in conveying this message.

In short, I believe a public education effort around wait times is warranted. If appropriately designed and delivered, the effort should also serve to raise overall public awareness of the health system itself.

7.2 Who is "the public"?

Public opinion research suggests a continuing high-level of concern by Canadians in regard to Canada's wait times performance, as well as a generalized perception that little progress has been or is

likely to be made in the coming years. Roughly half of Canadians believe that while each level of government has taken some action to reduce wait times, more can and should be done.⁵⁷ Furthermore those who indicated they were aware of recent FMM wait time commitments were more optimistic about the likelihood of progress. Since the opinions expressed vary only slightly from one group to another, “the public” for education and awareness purposes refers to all Canadians, including the media.

7.3 How Canadians are informed about wait times and implications for a public education plan

Officials developing or delivering the proposed public education program need to be mindful that there are significant differences among Canadians by age group, income, level of education, region etc. related to how and where they receive information about the health care system. They must also take into account the fact that various stakeholders exert a degree of influence over public perceptions of wait times. It is essential to partner with these groups in developing an overall public education effort. If “trusted” sources of information are not on-board at the outset, have not had a chance to provide input on how to frame or communicate key messages in regard to the transformations, the public education effort is unlikely to achieve its full potential. In addition, the potential for these disparate groups and constituencies to serve as information conduits to deliver information or reinforce key messages must also not be overlooked.

Public education efforts should:

- be developed in consultation with key stakeholders;
- provide stakeholders with an explicit role in delivering the plan to the extent possible;
- incorporate a multi-channel approach.

7.4 Goals of the public education effort

There appear to be three key areas on which a public education and awareness campaign on wait times could focus - none of which are mutually exclusive:

- *To improve public awareness of and manage public expectations in regard to, the health system’s performance regarding wait times (e.g. how the system works/does not work, and why; what is/is not an “acceptable” wait time; where problems exist, why and what is being done about them; when and how soon change will occur).*
- *To change perceived attitudes or behaviours of Canadians that may impede progress on improving wait times (e.g. resistance to e-health records or tele-health; reluctance to receive treatment from anyone other than a doctor; insistence on “choice” in regard to which specialists to see).*

⁵⁷ Pollara, *Health Care in Canada Survey*, 2005

- *To empower patients and encourage advocacy in regard to the transformations required to make durable progress on wait times* (e.g. to strengthen interdisciplinary collaboration among health professionals; to improve coordination at the local, regional, provincial and national levels; to encourage governments, health authorities or hospitals to make targeted investments in, or fast-track the adoption of: comprehensive wait lists; best-practices research; new curriculum development and training; coordinated HHR planning; health informatics; patient navigators).

7.5 Factors to consider

While there are a myriad of factors to consider, the most significant for the purposes of this effort are the following:

A sustained public education effort is needed and the payoff may be long-term

A common characteristic of many of the larger government-delivered or supported public education or social-marketing efforts of the past generation is that change proceeds incrementally. While there are clearly long-term benefits to be derived from a public education effort, expectations for what can be achieved in the short-term must be contained.

Focusing on a specific set of issues related to reducing wait times will produce better results

The scope, complexity and interdependencies of issues associated with improving Canada's wait time performance are substantial. This suggests the need to find an appropriate balance between overarching messages or objectives that would anchor the effort (e.g. "Fixing Wait-times for a Generation") and specific, targeted initiatives (e.g. "Making eHealth Records a Reality" or "Why Comprehensive Wait lists are Good for your Health"). A useful parallel to consider is the success that has been achieved in raising awareness among Canadians of the health risks of second-hand smoke for children within the context of a larger, more diffuse anti-smoking campaign.

Opportunities for coordinated "messaging" and partnerships should not be overlooked

The fact that any public education efforts in this area can arguably be viewed as a subset of a larger effort to improve overall public understanding of health system performance, makes the challenge of mounting a public education effort all the more daunting. Among the recommendations that are made in this chapter is the need to establish a clear focal point for developing and managing public education efforts in regard to wait times performance. Those assigned responsibility for this will need to capitalize on opportunities for shared outreach while identifying specific niches for the public education efforts they propose.

Public education must also include a media education component

Regardless of how ambitious or comprehensive the public education effort on wait times, the reality is that a single front-page headline in one of Canada's national newspapers, or a "special report" on the evening television news decrying the system's performance can undo any positive momentum that

might have been achieved. It is important to include a media relations component that goes beyond issuing media releases and responding to media requests. It is also important to distinguish between the print media and electronic media.

7.6 Public education on key transformations

The challenges associated with resolving the complex and interdependent aspects of wait time issues are considerable. The focus in relation to public education must be to increase “literacy” in order to manage expectations about what the system can deliver, encourage individuals to change behaviours and how they interact with the system *and* to become advocates for transformational changes. A well-designed public education strategy at both national and provincial levels has the potential to reduce resistance to the changes illustrated in Table 7.1 below.

Table 7.1:

FROM	TO
Cottage industry	Seamless system
Individual responsibility	Shared responsibility
Siloed	Integrated
Your doctor’s schedule determines how long you wait	The first available qualified doctor treats you
Paper-based Inequitable	e-based, IT system with central registry Fair
Powerlessness	Empowerment
A black hole where you fend for yourself	Patient navigators protect your interests
The interests of the system take precedence	A patient-focused/centered system
Individual doctors decide what you need	Health professionals work in teams

Other components could focus the broader “system transformations” essential to achieving progress on wait times. Some examples include but are not limited to:

Transformation 1: from individually-managed to centrally managed wait-lists

Transformation 2: from the ledger and log to modern health informatics

Transformation 3: from individual approaches to team-approaches to care

7.7 A pan-Canadian plan

Until it is necessary to sustain and reinforce key messages, examples of methods that could be used to promulgate wait time messages include:

- FPT collaboration on annual “best-practices” conference/workshop on wait times;

- FPT collaboration on a limited print ad campaign;
- FPT collaboration on annual public opinion research to assess progress and re-focus efforts as required;
- FPT collaboration on an annual newspaper/Macleans insert.

The benefit of a pan Canadian approach is that it would provide a visible and ongoing focal point of accountability for the individual and collective efforts of governments. If it is agreed that partnerships with key stakeholder groups are essential to achieve the transformations required for durable progress on wait times, the establishment of a more structured mechanism could be invaluable in facilitating these efforts.

7.8 Conclusion

In conclusion, it is evident that a public education campaign on wait times is essential to maintain public confidence in the future of the public healthcare system. Such a campaign would have the additional benefit of raising awareness about how Canada's health system operates. While the public education effort should focus primarily on the public at large, it should also take account of how public opinion is formed and influenced by key opinion leaders across Canada. This would require a multi-channel approach, including top down and bottom up outreach.

In order to achieve the full benefit and impact of such an education strategy, it is necessary for all key system stakeholders to be engaged in the design and delivery of the strategy and ensure they endorse and reinforce the key themes and messages. This will be assured through the development of an overarching campaign theme and with a limited number of messages focusing on transformation elements.

Ideally the campaign would be developed collaboratively and delivered by both levels of government.

Chapter 7: Public Education Recommendations

18. That the public be continually informed and updated of changes taking place in the Canadian health care system.
19. That a three-year public education campaign on wait times be initiated as a collaborative effort between federal, provincial and territorial governments.
20. That a comprehensive, multi-dimensional public education effort with the capacity to leverage support from other partnering organizations be undertaken.

Chapter 8: What the Future Holds

The effort and enthusiasm that is being applied to the management of wait times in Canada is very encouraging. The partnerships that are being created across the country, as wait times focus the energies of health regions, professions, institutions and facilities, are producing important results. New managerial, business and industrial practices are being investigated and applied, results shared and outcomes compared.

In this respect the future is bright. There are many good reasons why system transformation is necessary and many positive outcomes that will result if federal, provincial and territorial governments opt to continue down this road. As I have indicated throughout my discussions across the country the transformation of health care systems around the issue of wait times can have a more generalized effect on the system as a whole. There is substantial potential in this effort so long as the full breadth of patient-focused strategies are pursued.

I will reiterate them here:

1. **On-going research** is required to identify areas where the development of new benchmarks will be helpful. Operational research is required to ensure that business practices and system re-engineering hit the right mark. Those responsible for our health care systems need to know what the results of our wait time initiatives are, and so do Canadians.
2. **Re-engineering of our management, industrial and business practices** is essential. Many options are enumerated in this report and some of these options have already been implemented in systems across Canada. Our systems are complex and our work in this area will need continuous oversight and encouragement.
3. **Information technology** solutions must be implemented to improve communication and to ensure the availability of accurate and timely information throughout the continuum of care. Although IT can and will substantially improve the management of wait times, the need of caregivers to have correct and current information from primary health care to tertiary care is an equally important reason to pursue this objective.
4. **Cultural change** amongst health care professionals needs to accompany re-engineering of health care systems. Health care professionals play a critical role in leading change within delivery systems. New roles, relationships and responsibilities will require change on the part of physicians and other health professionals.
5. **Public Education** is essential if Canadians are to understand and support the kinds of changes that are required in health care and the sustained effort that will be required to get there. Articulating the vision is essential, as is the careful education that Canadians should reasonably expect about the elements of change. We require the patience of Canadians, their support and attention. Just as Canadians told us about unacceptably

long wait times, they will tell us about system transformation and whether or not our efforts are having the desired effect.

In some jurisdictions we have started to move in these directions. Despite having just begun, new issues and challenges are before us. There is no static time in the health care system. Change is a given and these new challenges are likely to emerge before our progress on wait times is completely secure. It is for this reason that apart from the transformative changes I have recommended, other aspects of health systems reform are essential as well.

I believe that preventative activities within public health programs are not optional to improving health systems – indeed many of us believe that earlier investments in comprehensive public health programs might have spared Canadians some of the health conditions that are pervasive now. Similarly, primary health care renewal is key - to ensure early identification of illness and risk factors and to provide the comprehensive care that patients deserve. Management of the prescription drug supply and new methods of financing drugs will be critical to sustaining our health care system. We must move on these fronts as well.

8.1 Patient Wait Time Guarantees

A new federal government has committed itself to the introduction of Patient Wait Time Guarantees. The timing of this commitment prompts me to make a few comments regarding guarantees, despite the fact that this issue was not explicitly included in the work that I was asked to do.

We can benefit from the experience of other countries. Several European countries have experimented throughout the 1990's with a variety of approaches to wait or care guarantees. These experiences can help Canadians understand more fully when wait time guarantees might be helpful, what their effect might be and what is involved with their administration. It is important to note that in European countries wait time or care guarantees were implemented in conjunction with other system reform initiatives.

Wait time guarantees can be defined or described in different ways, so that certain parameters of existing systems are protected or not protected. For example, in the United Kingdom and Sweden, care guarantees have been limited to the public domain, with choice of treatment being offered in another jurisdiction. Many choices are available to governments, depending on what alternatives they consider effective, timely or beneficial. It appears that wait time guarantees typically have the early effect of reducing wait times. This initially happened in Denmark where critical illness guarantees were later abandoned for a "general waiting time guarantee". Denmark's processes recognize that resources are not limitless, so those with the greatest need are given priority for care outside the local health care system.

Essentially wait time guarantees take advantage of capacity that exists elsewhere. In the Canadian system, which is geographically very large, we would ideally take full advantage of our local, provincial and national capacity before considering out-of-country options for care. The structure(s) of our health care system, its management and culture, all affect system performance and therefore outcomes. The consideration that these structural elements are now receiving, in this report and in policy or public fora, bodes well for the system's future.

I would like to suggest that the decisions taken in Quebec, that permit the province to pay publicly for services provided in the private sector,⁵⁸ are worthy of close attention. The Quebec plan allows for a period of trial, of a guaranteed wait time on a limited basis, with attention paid to the effects that such decisions have on the integrity of the system as a whole.

Although experience with wait time or care guarantees has been varied, wait time guarantees conceptually follow naturally from wait time benchmarks. I believe, however, that the process of identifying wait time guarantees, defining their scope and term, predicting their affect, must be done with care. We need to understand associated risks, benefits and costs of wait time guarantees before taking on more in the short term that we can reasonably support in the long term.

At the same time alternatives for system restructuring and re-design bring with them new or different principles and arrangements that are welcomed by some and alarming to others. The choices that we make in the next few years are important ones.

There are three principles necessary to a discussion of wait time guarantees. All of these principles require the support of provincial and territorial governments.

1. Evidence-based benchmarks are critical to the development of wait time guarantees;
2. System transformations as described in this report are necessary to underpin guarantees of any kind;
3. Maximum use of existing capacity and strategic development of new capacity is essential:
 - The development of regional networks of excellence can allow for more timely access in and between provinces. The concept of a network of excellence accepts that volumes of work and quality outcomes are closely related. This is especially the case in complex surgeries, when the demographics may offer a low volume of cases. (The capacity to build regional networks of excellence might be examined to some advantage in Canada where regions are created naturally – Atlantic Canada, Quebec, Ontario and Western Canada.) Creating additional regional capacity could result in direct wait list reductions. By redirecting care of low volume/highly complex procedures additional space for further wait list care could be identified. Federal, provincial, and territorial governments might wish to test the potential of this alternative by developing a series of regional pilot projects. If we make careful choices, regional networks of excellence would have the additional advantage of building new capacity to serve all Canadians, as and when required.
 - Other alternatives for capacity development should be explored through discussion with provinces and territories. In this context the alternative of contracting to private providers might also be considered. This should occur, however, 1) only when the purchase of private services results in greater advantage to the publicly-funded service than what would be achieved by

⁵⁸ This is in reference to the decision of the Supreme Court: Her Majesty vs. Chaouilli, June , 2005

- investing the same public funds in the public system and 2) where contractual conditions clearly specify volumes of care, anticipated outcomes and unit cost..
- Use of out-of-province access points, either in other provinces or in the U.S., represents an additional alternative. All provinces have used this mechanism from time to time to accommodate needs that have exceeded capacity. Most of these interventions have been of a short duration permitting more capacity to be developed locally. Out-of-province and out-of-country options are the most expensive way of providing health care services.

The choice of one policy option or another, or the combination of several, will affect the outcomes of our system and its cost. A thorough Federal, Provincial and Territorial discussion will be required.

8.2 Conclusion

The recommendations contained in this report will support effective use of our existing resources and will maximize the possibility that wait time guarantees might be met. If the transformation of health care systems were to be achieved through collaboration and synergy fostered amongst Canada's provincial health care systems, we could reasonably expect the vast majority of our wait list issues to be managed effectively.

I am hopeful that Federal, Provincial and Territorial Ministers will want to discuss the observations and recommendations of this report, many of which emanate from the experience, experimentation and wisdom of leaders, managers and professionals within their own health care systems. I believe that the implementation of these recommendations will bring about a new era of health care delivery in Canada and that patient experiences and outcomes would benefit significantly. I am also aware that the recommendations imply change that may be unsettling in some quarters or a challenge to manage. The ability of governments to take charge of these changes and bring them to fruition will increase if the efforts of our governments are synchronized and collaborative.

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