

# **Waiting Too Long: Reducing and Better Managing Wait Times in BC**

**A Policy Paper by the  
BCMA's Council on Health Economics & Policy**

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## Executive Summary

Wait lists remain one of the most significant problems facing our health care system. The importance of reducing waits has been raised in numerous health care reports. In the 2004 federal Throne Speech, the government stated that *“the length of waiting times for the most important diagnoses and treatments is a litmus test of our health care system [and] these waiting times must be reduced.”*

Public opinion surveys also highlight the importance placed on reducing wait lists. In a 2005 Pollara Poll, the highest number of respondents (43%) identified lengthy waits followed by a shortage of physicians (33%) as the most serious problems facing the health care system. A 2006 survey done by the Canada West Foundation found over 75% of respondents from the western provinces identified reducing patient wait times as a high priority. This was the highest ranking among 17 policy issues. The BCMA believes it is essential to provide a strategy to help reduce and better manage wait times within BC's health care system. In addition to providing recommendations, we provide a thorough environmental scan on what BC and other jurisdictions have done in the area of wait lists.

Lack of reliable data and disagreement on a definition of wait lists exacerbates the debate and efforts to find solutions. Data on provincial waits in BC are currently available from two main sources: the Ministry of Health and the Fraser Institute. Both sources conclude that patients continue to face lengthy waits for booked surgeries, although estimates conflict due to different methodology. A standard definition is needed if we are to measure accurately how long patients are actually waiting for surgical and diagnostic procedures and to address effectively the challenges of those waits.

To address the wait list problem, the federal government has responded with two major initiatives. First, \$41 billion of federal funding was announced in 2004 as part of the First Ministers 10-Year Plan to Strengthen Health Care. This funding 1) stipulated that provinces achieve meaningful reduction in five priority areas (cancer, heart, diagnostic imaging, joint replacements and cataracts) and; 2) created a \$5.5 billion ten-year Wait Times Reduction Fund. Second, in December of 2005, federal and provincial Health Ministers announced ten benchmarks aimed at cutting wait times for medical services.

BC's share of the Wait Times Reduction Fund will total approximately \$715 million over the entire ten years of the plan. It is unclear how the provincial government plans to spend its share of the federal funds allocated for wait time reductions. The BCMA recommends that a significant portion of the new funding allocated until 2009/10 be used to increase the capacity of the acute care sector so that benchmarks may be achieved.

These are good first steps. Reducing wait times begins with accurate measurement so that actual wait times can be compared to benchmarks and progress monitored, policy adapted and funding directed accordingly. The focus on reducing waits should not be just on the five priority areas identified by the First Ministers. Waits for other procedures or areas of the health care system must not be ignored.

## Wait Time Management

Along with individual provincial and Health Authority initiatives to reduce wait times, BC has collaborated with the other western provinces through the Western Canada Waiting List (WCWL) Project, which was funded by the federal Health Transition Fund and had the goal of developing tools that provide a clinically transparent method of prioritizing patients for wait listed services.

Other jurisdictions and organizations in Canada have also studied wait lists and wait times and presented policy recommendations. The Wait Time Alliance (WTA), consisting of six medical specialty societies and the CMA, has proposed establishing benchmarks for the five priority areas and guidelines for funding wait list management.

There are various supply and demand policies that can be used to better manage and reduce wait times. Supply policies include increasing the number of surgical procedures, expanding the capacity of the acute care sector, improving surgical productivity, introducing service-based funding for hospitals, and greater use of the private sector. Demand side policies involve better managing demand for surgical procedures in the health care system, including the clinical prioritization of patients on waiting lists and the better auditing of wait lists. In principle, supply side policies should be used to reduce wait times if the number of procedures is not considered adequate, while demand side policies should be used if volume is considered adequate. The key is determining what is adequate.

## The International Scene

Almost every country with a publicly funded health care system has some issue with access to services and waiting. Wait times tend to increase in countries that combine public health insurance (with zero or low-cost sharing) and constraints on capacity. Including Canada, one-half of OECD countries report problems with wait times for elective surgeries.

Denmark, France, Germany, Switzerland and the US have no significant wait time problems for scheduled procedures. These countries tend to have a higher availability of equipment, acute care beds and health care providers, and allow some access to private hospitals. Australia, Ireland, New Zealand, Norway, Spain, Sweden and the UK do have wait time problems for scheduled procedures. Each of these countries has recently adopted measures to reduce wait times, including contracting out services and allowing treatment in other jurisdictions when care needs cannot be met domestically.

## Recommendations

Wait times are too long in BC. This includes waits to see a GP or specialist, waits in Emergency Departments and waits for post-acute care including rehabilitation, home care and long-term care.

Immediate action is needed. The BCMA is making the following 29 recommendations based on existing evidence and research, under five categories:

1. Building capacity;
2. Establishing wait time benchmarks for diagnostic, therapeutic and surgical services;

3. Developing and implementing wait list management tools;
4. Improving accountability; and
5. Funding.

Additional acute care and long-term care beds must be added in BC. Routine acute care bed capacity not exceeding 85% should be maintained in hospitals, and the government should fulfill its commitment to increase the number of long-term care beds by 5,000 by 2010. Operating room capacity should also be increased by at least 25% within the next two years and an additional expansion of 25% should be realized by 2009/10. With regard to diagnostic equipment, a task force should be established immediately to develop strategies for increasing the availability and effective use of diagnostic equipment province-wide.

Building capacity requires that provider shortages, including physicians and nurses, are addressed. The introduction of physician assistants could help in this regard. Building capacity will also require the development of “speciality clinics” focussing on specific procedures as well as the appropriate use of public-private partnerships and the contracting out of services.

The management and reduction of wait lists must not be focused just on the five priority areas identified by the First Ministers (i.e., sight restoration, cancer care, cardiac care, joint replacements and diagnostics). Although these are important areas, it is critical that waits for other procedures or in other areas of the health care system not be ignored. The fundamental purpose of this paper is to explore means to reduce *all* waits in all areas of the health care system. In particular, Emergency Department (ED) waits must be addressed as an immediate priority.

To increase accountability and to ensure patients know their maximum possible wait and benchmarks for all major diagnostic, therapeutic and surgical services should be introduced no later than December 31, 2007. Such benchmarks and targets should be based on medical outcome evidence and professional opinion. Along with specific benchmarks, there should be a maximum six-month waiting time benchmark from GP referral to the provision of any medically required service. Greater accountability requires that the government pay for the treatment, travel and other appropriate costs for patients who must travel to other jurisdictions to receive services within wait time benchmarks.

Reducing overall wait times will require that wait lists are better managed through various tools such as central registries, clinical guidelines, best practices, information technology and incentives. The BCMA supports the continued development and implementation of central registries in BC, like the Provincial Surgical Services Project (PSSP). The development of central registries must include meaningful input from practising physicians, patients, professional regulatory bodies and privacy agencies. Likewise, the central wait list registry must be updated and audited on a regular basis to ensure the accuracy and integrity of data. The privacy of patient information in central registries must also be protected through audit trails and authentication mechanisms. The development of central registries relies heavily on the development of IT systems in health care facilities and physicians’ offices.

Clinical guidelines and best practices are critical for better managing wait lists. The BCMA recommends that the development and implementation of guidelines continue to be supported and funded by government. We also recommend, based on international experiences, that the BC government develop

a program to reward best practices in hospitals, surgical facilities and post-hospital care for improving patient outcomes and providing incentives to reduce wait times.

The recommendations in this paper require that accurate wait list data is readily available to the public and health care providers. The BCMA advocates the development of standardized approaches and definitions, supported by appropriate information systems, to measure how long patients are actually waiting for procedures. Likewise, the BC government and Health Authorities must report accurate wait list times in a clear and concise manner to patients and health care providers on a monthly basis. Total wait times should be measured from time of GP referral to the provision of service. Performance Agreements between the BC government and Health Authorities should include specific wait time benchmarks with incentives to meet performance targets.

The BCMA recommends the creation of a BC Wait Times Commission (BCWTC) to make recommendations regarding targeted wait time funding. The BCWTC should be comprised of representatives from the BCMA, BCNU, Ministry of Health and Health Authorities. It should be responsible for monitoring the progress of all wait list initiatives in the province, report annually on the health care system's performance in meeting clinically defined benchmarks, and make recommendations on how to improve patient access to timely care. The BCWTC should, as one of its first tasks, develop a 10-year funding strategy to reduce waits in BC. This 10-year framework should outline detailed funding commitments for the following:

- Increasing the number of acute and long-term care beds
- Increasing operating room capacity
- Diagnostic equipment
- Reducing pressures in Emergency Departments
- Increasing the supply of physicians and other health care professionals
- Establishing specialty clinics
- Developing central patient registries and prioritization tools
- Ensuring best practices for reducing wait times, including incentives for hospitals and physicians to reduce wait lists
- Enhancing information technology
- Ensuring government, providers and patients are accountable for results

Reducing waits will require additional funding. Research shows that additional funding, if properly targeted, is effective in reducing waits. The BCMA believes that funding should be given to those services and/or regions where access issues are most significant. As a short-term goal, targeted funding should be provided to bring the province into compliance with established wait time benchmarks. As a long-term goal, timely access must be available for all medically necessary services in BC.

# I. The Wait List Problem

The problem of excessive waits is one of the most pressing policy issues affecting our health care system, and it has been the subject of several BCMA publications (summarized below). To begin to understand the extent of the problem, it is helpful to look at three aspects: first, how long patients in BC wait for elective surgery; second, how these waits compare with the rest of Canada; and third, public and physician opinion on the issue.

## BCMA Wait List Publications

The first two BCMA publications addressing the issue of wait lists, *Wait List Reports I & II* (1998), were based on surveys of specialists in BC. These reports documented unacceptably long wait times for urgent and elective cardiac surgery, orthopaedic surgery, ophthalmology, emergency medicine, general surgery, neurosurgery, and diagnostic services. Other problems discussed included unacceptably high surgery cancellations and long waits to see specialists. The reports concluded that the government must adequately fund medical services in BC in order to keep pace with the growth and aging of BC's population, and that the Ministry of Health must commit to improving data acquisition ability and public access to information on waiting lists in BC. There was no direct response from government to the findings of *Wait List Reports I & II*. However, \$41 billion of new federal funding – a portion of which is devoted to reducing wait times – was announced in the 2004 First Ministers' 10-Year Plan to Strengthen Health Care.

The *Wait List Reports* were followed by *Patient Care Guarantees* (2003), which recommended the introduction of patient care guarantees for diagnostic, therapeutic and surgical treatments. The paper further recommended that a significant portion of the new federal funding be used to increase the capacity of the acute care sector so that patient care guarantees can be managed. It also recommended establishing a task force to develop a strategic plan for the implementation of patient care guarantees. To date, no such task force has been established, and it is unclear how the provincial government plans to spend the majority of its share of the federal funds allocated for wait time reductions.

Finally, in November 2004, the BC Nurses' Union (BCNU) and the BCMA issued a joint statement entitled *A Strategy to Reduce Orthopaedic and Ophthalmology Waits in British Columbia*. The statement noted that the greatest limiting factors in reducing these waits were a shortage of nurses and surgeons. It advocated the creation of a Wait List Reduction Steering Committee (WLRC) comprising equal representation from the BCMA, BCNU, the Ministry of Health, and the regional Health Authorities. Again, there was no direct response from government and the WLRC was not created.

## Accurate Wait List Data

Data on provincial waits in BC are available from two main sources: the BC Ministry of Health and the Fraser Institute. Both these sources are useful, and both suggest that patients continue to face lengthy waits for elective surgeries. However, there remains a clear need for accurate information, collected over time in an objective and comprehensive fashion.



### Ministry of Health Data

The Ministry of Health calculates median patient waits based on the difference between the time the hospital booking is made and the actual surgery performed. Because this measure does not include any waits prior to the hospital booking (e.g., wait to see specialist), it tends to underestimate the actual patient wait. Nonetheless, the data reveal growing waits for a number of procedures. With the exception of urological surgery, wait times for all surgeries increased between June 2001 and December 2003, with the greatest increase for vascular surgery (35%), gynecological surgery (23%), general surgery (10%) and eye surgery (10%).<sup>1</sup>

The most recent data from BC show that the new targeted funding from the federal government may be reducing wait times for specific procedures. For example, according to figures from the Surgical Wait Times website, the median wait times for hip and knee replacements in BC has decreased between June 2005 and April 2006 (22.6 to 20 weeks for hip replacements and 27.9 to 24.7 weeks for knee replacements). Despite new funding, however, the median wait time for cataract surgery remained at 7.6 weeks. The median wait time for all orthopedic surgeries also increased during the same period from 7.4 weeks in June 2005 to 8.3 weeks in April 2006. When averaged across all procedures, the median wait times decreased from 5.9 weeks to 5.5 weeks during this period.<sup>2</sup>

### Fraser Institute Data

In its annual survey of physicians on waiting times in British Columbia, the Fraser Institute reports substantially longer waits than does the Ministry of Health. This may be attributed to several differences in methodology. First, the Ministry of Health data may encompass non-elective surgeries by including procedures booked less than 24 hours prior to surgery, thereby reducing the median wait time. Second, the Ministry measures a wait beginning at the time of the hospital booking, whereas the Fraser Institute also measures from the time of the specialist referral. Finally, the Ministry of Health bases its estimates on hospital booking records, whereas the Fraser Institute uses physician survey data.

### Wait Times in Other Areas

Wait lists in BC are prevalent in many other areas of the health care system. For example, it is increasingly difficult to find a general practitioner (GP) to provide basic primary care. Currently over 150,000 citizens in BC do not have a family physician, and the number of GPs accepting new patients has declined from 1,420 in April 1999 to 599 in March 2004.<sup>3</sup> In addition, more family physicians are reducing their scope of practice.

Another area of concern is waits for emergency care. In 2000, BC emergency physicians stated that the median wait time for treatment in the Emergency Department (ED) was 1.1 hours, almost twice as long as what physicians believed was reasonable (0.6 hours). The reported median wait for admission from the ED to a hospital bed was worse at 12 hours – 10 hours longer than the median reasonable wait time of 2 hours. Seventy-seven percent of emergency physicians also reported that the lack of inpatient beds inappropriately causes delay to hospital admissions on a daily basis.<sup>4</sup> In a 2005 survey by the Commonwealth Fund, 42% of patients in Canada with reported health problems stated that they waited

over two hours for emergency care in the past two years, which was higher than Australia, Germany, the UK, the US and New Zealand.<sup>5</sup>

On the whole, urban hospitals with higher patient volumes see more patients in the EDs. Hospitals in urban areas and those affiliated with medical schools tend to have larger volumes of ED visits than those in rural areas or those not affiliated with medical schools. For example, in Ontario, high-volume community hospital EDs (those with over 30,000 visits annually) captured almost 50% (47%) of emergency department visits in 2003/2004.<sup>6</sup>

## Public and Physician Opinion

### Public Opinion

In the 2003 Statistics Canada Health Services Access Survey, Canadians identified wait times as the major barrier to accessing specialized health care services. The survey found that 13% of those who accessed non-emergency surgery experienced difficulties. The results were highest in BC, with 20% experiencing difficulties. Among those who had waited for non-emergency surgery, BC had the highest rate, with 25% considering their waiting time unacceptable.<sup>7</sup>

Similar concerns are echoed in recent opinion polls. In a 2004 Canadian Medical Association/Ipsos Reid poll, two-thirds of respondents reported that they waited too long for access to health care services over the past year.<sup>8</sup> Similarly, a May 2004 BCMA/Ipsos Reid poll found that 91% of respondents were concerned about waiting times for surgery and 87% were concerned about waiting times for diagnostic procedures. Of those respondents reporting that they waited longer than they believed reasonable, 60% experienced increased pain or discomfort and 42% experienced deteriorated health or worsened condition.<sup>9</sup>

### Physician Opinion

The consensus among physicians is that patients are waiting too long. A 2004 Ipsos Reid survey found that physicians believe access to health care services has worsened over the last few years. The decline is most evident with respect to access to family doctors (73%), specialists (66%), hospital emergency rooms (61%) and surgical procedures (59%).<sup>10</sup>

## Current and Reasonable Waits for Selected Procedures

A number of organizations, including the BCMA and the Fraser Institute, have developed maximum or medically reasonable wait times or benchmarks for selected procedures. Such measures are necessary to manage wait lists and maintain accountability for government.

### BCMA

In previous BCMA wait list reports, BC physicians were surveyed on what they believe are reasonable wait times. In *Wait List Report 1*, physicians on average stated that a reasonable wait for elective coronary artery bypass surgery was 7 weeks, 8 weeks for hip or knee replacements, 8 weeks for cataract removal and 2 weeks for a CT scan.

In *Wait List Report II*, which focused on emergency medicine, general surgery and neurosurgery, physicians stated that on average a reasonable wait for an elective hernia repair was 4 weeks, while actual waits were closer to 9.3 weeks. For a cholecystectomy, physicians stated that a reasonable wait was 3 weeks while the actual wait was closer to 10 weeks.

### **The Fraser Institute**

The Fraser Institute's annual survey also asks physicians what they believe is a reasonable wait times for selected surgeries. Their data show that the difference between the actual versus reasonable waits between appointment with specialist and treatment has increased significantly from 1994 to 2004. While physician estimates of reasonable waits have remained relatively constant over time – between 4.2 to 5.5 weeks – the actual time has increased from 7.5 weeks in 1994 to 11.2 weeks in 2005 (a 50% increase).

### **Health Ministers' Benchmarks**

In December 2005, Health Ministers across Canada unveiled 10 key benchmarks aimed at cutting wait times for medical services. These benchmarks reflect the time that clinical evidence shows is appropriate to wait for a particular procedure; they are not care guarantees or legal obligations to individual patients. The benchmarks include:

- Radiation therapy to treat cancer within four weeks of patients being ready to treat
- Hip fracture treatment within 48 hours
- Hip and knee replacements within 26 weeks
- Surgery to remove cataracts within 16 weeks for patients who are at high risk
- Breast cancer screening for women aged 50 to 69 every 2 years
- Cervical cancer screening for women aged 18 to 69 every 3 years after two normal tests
- Three benchmarks for cardiac bypass surgery depending on how urgently care is required: Level I patients within 2 weeks; Level II within 6 weeks; Level III within 26 weeks

In summary, reducing wait times begins with measurement. Once accurately measured, actual wait times can be compared to benchmarks, and policymakers can monitor progress, adapt policy and direct funding accordingly. Determining clinically reasonable wait times and targets based on sound medical and scientific outcome evidence will be a critical component of better management of wait times. However, most of those targets mentioned function as “sentinel” measures. They are, so to speak, the canaries in the mineshaft. An overemphasis on the few services for which national benchmarks have been announced, to the exclusion or detriment of others, would be akin to rushing oxygen to the canaries and forgetting the miners! Policymakers must place the achievement of specific wait time benchmarks in proper perspective in order to be effective in improving wait times across the health care system.

## II. Wait List Management Techniques

### Why Wait Times Exist

Various factors determine the overall length of wait times. In a 1998 survey from Queen's Health Policy of health care providers, administrators and consumers, inadequate funding was ranked as the primary factor contributing to wait times. The factors included (from most important to least important):

- Inadequate funding
- Aging population
- Ineffective management of current resources
- Hospital restructuring
- Health care provider shortages
- Change in disease patterns
- Restricted access to technology
- Past failure to invest in prevention
- Patient expectations<sup>11</sup>

In a 2004 survey from CMA/Ipsos Reid, physicians identified multiple factors responsible for diminished access to health care and an increase in wait times, including higher incidence of chronic disease among Canadians; shortages of health care professionals, hospital beds or medical equipment; and inadequate funding.<sup>12</sup>

### Supply and Demand Policies for Reducing Wait Lists

There are various supply and demand policies that can be used to better manage and reduce wait times. Supply policies include initiatives designed to increase the number of surgical procedures such as increasing public expenditures, improving surgical productivity (i.e. best practices), expanding the capacity of the acute care sector, service-based funding for hospitals and greater use of the private sector.<sup>13</sup> More specific examples could include ensuring that peri-operative capacity is being maximized by adopting best practices in areas such as turnaround times and peri-operative procedure times. Best practices could also include the use of modern queuing methods, the effective utilization of physician resources as well as utilizing clinical urgency indicators and other methods to improve the flow of appropriately queued patients into the system.

Demand side policies involve either reducing or better managing demand for surgical procedures in the health care system. Examples of demand policies include the clinical prioritization of patients on waiting lists and the better auditing of wait lists.

In principle, supply side policies should be used to reduce wait times if volume is not considered inadequate, while demand side policies should be used if the number of procedures is considered adequate.<sup>14</sup> The key policy issue is determining what is adequate.

## How to Measure Wait Times

There are no standard or universally accepted definitions of wait times. Depending on the definition used, estimates of wait times may vary significantly. As previously stated, the Ministry of Health measures a wait beginning at the time of the hospital booking, whereas the Fraser Institute measures waits beginning at the time of the specialist referral. Different again is the College of Family Physicians of Canada, which argues that wait times should be measured from the time the symptoms are first experienced by a patient and attempts to seek care from a family physician.

Wait lists can also differ by looking at the mean or median wait times. In BC, the Ministry of Health, through its Surgical Registry, uses median wait times: the point at which one-half of the patients have had their surgery and the other half are still waiting. This is the preferred approach, as long as due attention is paid to outliers.

How wait time information is determined can also differ. For example, wait list data from the Fraser Institute is based on the self-reported responses of physicians, while the BC Surgical Registry uses information reported from hospitals. Self-reported surveys may provide a useful snapshot of patient and physician perceptions, but are subject to response bias depending on the questions asked, when they are asked (i.e., problems recalling information), sample size and response rate. On the other hand, data generated by hospital and physician billing claims is only useful for monitoring waits for procedures that are recorded. Hospital booking systems can track the length of waits for specific procedures within an institution, but do not provide information on relative urgency and priority of patients.<sup>15</sup>

In BC, as in other provinces, most wait lists are generally created and maintained in the offices of individual physicians or hospital surgical departments, rather than in a regional Health Authority or other coordinating agency. However, an initiative by the Provincial Health Services Authority (PHSA) – the Provincial Surgical Services Project (PSSP) – seeks to create a province-wide surgical services registry. The PSSP is focusing its efforts on developing provincial standards and guidelines for surgical services and creating data collection processes for better resource planning and decision making (e.g., a provincial surgical registry).<sup>16</sup>

## III. Wait List Management in British Columbia

### Factors Contributing to BC's Wait List Problem

Several factors contribute to the problem of wait lists. One is the lack of capacity in the existing system, including a shortage of providers, acute/long term care beds, operating room (OR) resources, etc. Another is how wait lists are managed.

#### Lack of Capacity

A 2004 report from the BCNU and BCMA highlights the problem of lack of capacity, showing that many ORs are not being utilized to their maximum capacity. In BC, the acute/rehabilitative bed to 1000 population ratio of 1.8 is well below the 2.75 recommended by the BC Royal Commission on Health Care and Costs (1991) and ranks 26<sup>th</sup> of 30 the OECD countries.<sup>17</sup> In fact, the shortfall from the Royal Commission recommendation translates into over 3,900 beds, or a 35% deficiency.

The BCMA policy paper entitled *Specialty Care in BC: A System in Distress* (2004) outlines major problems such as access to hospital beds, operating rooms, diagnostic equipment, home and community care programs; waits for referral; supply of physicians and other health professionals; and emergency room waits.

In 2004, the National Physician Survey asked physicians to rate patient access to different clinical services. In this survey BC physicians highlighted significant problems including access to long-term care beds, elective procedures, orthopaedic surgeons and palliative care.

#### Management of Wait Lists

Wait lists are not managed optimally in BC. A 1992 study of secondary and tertiary care institutions, for example, revealed that 10 of 17 hospitals' lists were compiled in the offices of individual surgeons, and in 13 of 17 institutions the decision on the next patient to be admitted was made by individual surgeons. None of the hospitals, however, had guidelines for compiling or using waiting list data and none coordinated their lists with nearby institutions.<sup>18</sup> Although no recent studies have been done on how wait lists are currently compiled, for the most part, the situation has not changed. For example, regions, hospitals and doctors will have their own wait lists depending on the type of surgery or procedure. With few exceptions, there are also no valid and reliable means used to assess the priority of patients on waiting lists, thus making it impossible to manage regional lists to ensure that patients with the highest urgency are served first. On a positive note, some initiatives such as the Provincial Surgical Services Project (PSSP) in BC are addressing these issues.

## Recent Provincial Government Initiatives on Wait Lists

Over the past few years, the BC government has announced the following wait list initiatives:

- March 2004: \$20 million to provide greater access to medical services and to reduce wait lists. The one-time funding would provide an additional 80 open heart surgeries, 400+ hip and knee surgeries, 3,600+ diagnostic procedures and 500+ cataract procedures.<sup>19</sup>
- August 2004: \$5 million to improve access to cardiac care through the Provincial Health Services Authority (PHSA).<sup>20</sup>
- September 2004: \$20.7 million to improve patient access to hip and knee replacement surgeries (\$16.7 million) and diagnostic procedures (\$4 million).<sup>21</sup>
- October 2004: \$20 million to improve radiation therapy services and increase cancer treatment access for thousands of patients.<sup>22</sup>
- December 2004: \$35 million for medical technologies including the first publicly funded Positron Emission Tomography (PET) Scan unit in the province.<sup>23</sup>
- February 2006: \$60.5 million to reduce wait times for hip and knee replacements, including \$25 million for a new Centre for Surgical Innovation with dedicated operating rooms for 1,600 additional surgeries; \$25 million to the Health Authorities to increase the number of surgeries with a focus on joint replacement surgery; \$5 million to create and implement a province-wide patient registry; and \$5.5 million for a Research Centre for Hip Health at Vancouver General.<sup>24</sup>

Although the extra funding to reduce wait lists is positive, systemic changes to the way wait lists are managed must also take place. Aside from the creation of a Centre for Surgical Innovation dedicated to joint replacements, the new funding announcements provide little in the way of improving the management of wait lists.

## Health Authorities' Initiatives to Reduce Wait Lists

Recently there have been some successes in reducing wait lists at the Health Authority level. For example, in a March 2005 press release, the Arthritis Society (BC & Yukon) noted that the Health Authorities estimated that the \$16.7 million announced in September 2004 would allow them to perform 39% more hip and knee surgeries in 2005 than in the previous year.<sup>25</sup> The Vancouver Coastal Health Authority also reports that between July 2004 and August 2005 they reduced the number of patients waiting more than 24 weeks for hip and knee surgery within the region by over 20%.<sup>26</sup>

With new Ministry of Health funding, the Provincial Health Services Authority (PHSA) states it has reduced wait lists for open heart surgery by more than a third, from 623 in June 2003 to 409 in April 2004, while reducing median wait times from 18 weeks in November 2003 to 14.9 weeks in April 2004.<sup>27</sup> As well, the PHSA is leading many of the province-wide initiatives to reduce surgical wait lists.

One such initiative led by the PHSA is the Provincial Surgical Services Project (PSSP). The goals of this project include the development of province-wide measures of performance for surgical and procedural services, including wait list standards. The process will include establishing measures of performance of the system in response to emergency treatments and procedures and the development of principles for establishing priority for care for non-emergency conditions/cases.<sup>28</sup> The focus is to develop clinical assessment tools, sharing of best practices and a renewed surgical registry for Health Authorities.

A major task of the PSSP is to create a Surgical Wait List Registry that produces more clinically relevant, accurate and comprehensive information with surgeons using consistent processes to classify their patients' surgical needs. New clinical assessment tools for 12 surgical specialties were to be tested at hospitals across the province in 2005, with a target for their full introduction by the end of that year.<sup>29</sup> At present 14 tools are being completed by various surgical specialty groups, of which 13 have been successfully piloted. Currently 36 pilots are underway in BC, with one Health Authority piloting all of the assessment tools. The anticipated full rollout of the assessment tools is expected in mid-2007. Once completed the Provincial Surgical Registry will replace the existing Ministry of Health Surgical Wait List Registry to track all patients waiting for surgical procedures.<sup>30</sup>

PHSA has also launched the Provincial Emergency Services Project (PESP) in an attempt to improve access to, and the effectiveness of, BC's emergency health services system. To lead the PESP, a Provincial Emergency Services Steering Committee (PESSC) comprised primarily of Health Authority and Ministry representatives was created. One of its goals was to establish and direct a task force to identify and prioritize emergent problems and recommend solutions. This task force released a report in April 2003 highlighting some of the major problems facing EDs including nursing staff shortages, specialist shortages, overcrowding in the ED, and inter-hospital transfer. It is not clear whether these recommendations have been implemented, as no further progress reports have been released.

One of the most recent initiatives being led by the VCH is the creation of a \$25 million Centre for Surgical Innovation with dedicated ORs to perform 1,600 additional hip and knee surgeries over the next year. The UBC Hospital Centre for Surgical Innovation will include two ORs in April 2006 for joint replacement surgery as well as 38 inpatient beds. The specialized centre will also promote best practices in surgical processes, establish triage guidelines for wait list patients and develop a best practices clinical toolkit for other BC hospitals.<sup>31</sup> According to VCH by the end of the first year, the UBC Centre for Surgical Innovation will have increased access to hip and knee joint surgeries by approximately 20%.<sup>32</sup> As part of its Balance Scorecard, VCH has set a target of having 90% of patients waiting for hip and knee replacements treated within 26 weeks.

### **Collaborative Projects Between the Health Authorities**

The PHSA and VCH have teamed up to reduce wait times for pediatric day care surgeries. As of April 2005, select pediatric day procedures currently provided at BC Children's Hospital will be performed by Children's surgeons at Richmond Hospital. Once the service is fully operational it is anticipated that around 700 to 800 cases will be provided each year, improving access to acute secondary services for children throughout Vancouver Coastal Health.<sup>33</sup>

In March 2005, Vancouver Coastal Health (VCH) and the Provincial Health Services Authority (PHSA) also unveiled a working pilot at Richmond Hospital, the Hip and Knee Reconstructive Project. The project resulted in approximately 200 additional hip and knee procedures being completed by the end of March 2005. One of the major goals of the pilot project is to develop a "toolkit" that other hospitals in the province can use to perform more hip and knee surgeries and reduce the average length of stays. The toolkit will include patient and surgeon outcome measurements, a wait list prioritization tool and a documented Regional Hip and Knee Clinical Pathway. A sixth OR has also been opened at Richmond Hospital to support the project.<sup>34</sup>



## IV. Wait List Management in Canada

In Canada, wait lists and wait times have been the subject of numerous national reports, each with its own focus and policy recommendations. A summary of some of these reports is presented here. As well, governments at both the federal and provincial levels have been involved in wait list reduction strategies in a variety of contexts.

### Canadian Medical Association

The Canadian Medical Association (CMA) has defined two goals for the effective management of surgical waiting lists: 1) to maintain or enhance patients' quality of life and health; and 2) to ensure that the development and management of wait lists is based on the best available evidence of clinical appropriateness, clinical effectiveness, rational use of resources, clinical need and quality of life.<sup>35</sup>

In *Better Access, Better Care* (2004), the CMA recommended the establishment of a Canada Health Access Fund, pan-Canadian wait time benchmarks and a network of regional registries and referral systems. It suggested that financial support should be made available to patients who must travel out of province or out of country. More specifically, it recommended that the federal government should contribute \$1 billion over 5 years to cover 50% of the case-mix adjusted costs associated with out-of-jurisdiction care.

### The Wait Time Alliance

The Wait Time Alliance, which consists of six medical specialty societies and the CMA, was formed to establish evidence-based benchmarks in the five priority areas outlined in the 2004 First Ministers 10-Year Plan to Strengthen Health Care.<sup>36</sup> The Alliance proposed the following actions:

- Create a steering committee to develop a wait time strategy along with five separate expert tables to develop wait time benchmarks for each of the five priority areas
- Develop a pan-Canadian approach to collecting wait time data to ensure the consistent measurement and monitoring of wait times across the country
- Set realistic targets to meet benchmarks as soon as possible in the five priority areas
- Monitor progress toward reducing wait times
- Establish a targeted health services research program.<sup>37</sup>

In August 2005 the Wait Time Alliance released its final report, *It's About Time!* Along with establishing new benchmarks, it outlined these major recommendations:

- The federal government create a 5-year \$1 billion Health Human Resources Investment Fund
- Wait time targets in the five priority areas be established by March 31, 2006, 21 months ahead of schedule
- Federal, provincial and territorial governments establish a 5-year \$2 billion Health Access Fund to enhance portability of care for patients and their families by reimbursing the cost of out-of-province or out-of-country care when the services are not available provincially within the accepted wait time benchmarks.

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## Federal Government Activities

### Health Council of Canada

The first Annual Report from the Health Council of Canada (2005) highlighted the importance of better managing wait lists. For example, it stated that the criteria physicians use for placing patients on wait lists vary widely, as do their practices for monitoring, reordering the list according to patients' needs and removing people who no longer belong.

In its second Annual Report, *Health Care Renewal in Canada: Clearing the Road to Quality* (2006), the Health Council outlined several suggestions including improving public information on wait times and focusing on appropriateness of care and health outcomes. The report also advocated the development of a package of reforms to reduce wait times.

### Federal Wait Times Reduction Fund

BC's share of the First Ministers 10-Year Health Plan to Strengthen Health Care fund is approximately \$600 million over the first 6 years of the agreement.<sup>38</sup> As part of this agreement, First Ministers are to achieve meaningful reductions in wait times by March 31, 2007 in the priority areas of cancer, heart, diagnostic imaging, joint replacements and sight restoration.<sup>39</sup>

Evidence-based benchmarks for medically acceptable wait times were set to be established by December 31, 2005. In December 2005, Health Ministers across Canada unveiled 10 key benchmarks aimed at cutting wait times for medical services for all priority areas except diagnostic imaging. Each jurisdiction is also to establish its own indicators for access and benchmark targets for wait times. In particular, multi-year targets will be developed to achieve the priority benchmarks by December 31, 2007.

### Federal Medical Equipment Fund

In 2000, a \$1 billion fund was established to assist provinces and territories to purchase and install medical equipment according to their own priorities. BC's portion was approximately \$132 million.

Further, in February 2003, Canada's First Ministers agreed to a new Health Care Action Plan. Of the \$34.8 billion provided by the federal government over 5 years, \$1.5 billion went toward a 3-year Diagnostic and Medical Equipment Fund. BC's portion is approximately \$200 million.

## How Provinces Have Managed Wait Lists

Despite wait lists in Canada being managed largely on an ad-hoc basis with inaccurate data, there are initiatives underway in the provinces that should be explored further. Note that some of the targeted funding described in the following sections will not reduce wait lists, but rather maintain current levels of access. Appendix C provides a summary of wait times for selected treatments among the provinces where information is available.

## Alberta

In 2003, an online wait list registry was launched to publish wait times for surgeries and diagnostic tests performed by specific surgeons and health professionals in certain Alberta hospitals.<sup>40</sup> The registry shows the times patients may have to wait before receiving a procedure from a specific physician or health care provider.<sup>41</sup>

In its report released in January 2003, the Alberta Premier's Advisory Council on Health recommended a comprehensive 90-day care guarantee for a select number of services.<sup>42</sup> An expert advisory panel was later established to develop an implementation plan, but advised against the enactment of a rigid care guarantee in favour of a more flexible definition of reasonable access to timely care based on procedure-specific evidence.<sup>43</sup>

### *Alberta Hip and Knee Replacement Pilot Project*

To deal with the increases in the number of people waiting for hip or knee replacements, the province funded a \$125 million centre of excellence in bone and joint health in Calgary and allocated \$20 million for additional hip and knee replacements in the Calgary, Edmonton and Red Deer health regions.<sup>44</sup> As part of the \$20 million Alberta Hip and Knee Project, patients are assessed at a central clinic to streamline the referral process.

Interim results from the project showed significant improvements. The wait time for a specialist consultation dropped from 35 weeks to 6 weeks. The wait time from consultation to surgery also dropped, from 47 weeks to 4.7 weeks.

In March of 2006, the Alberta government announced an additional investment of \$54 million in new projects to reduce wait lists. \$12 million of this funding will be used to sustain and expand the current hip and knee replacement project, while the remaining \$42 million will go towards supporting the development of innovative models of care for health services such as cardiac care as well as breast and prostate cancer care. In particular, the new projects will build on the success of the Alberta Hip and Knee Replacement Project.<sup>45</sup>

## Saskatchewan

In 2002, a report was released by a task team that was established to advise Saskatchewan Health on surgical wait list issues. This report advocated various recommendations to improve wait list management, including the creation of a Saskatchewan Surgical Care Network (SSCN).<sup>46</sup> This initiative aims to implement the country's first comprehensive system to rate and track all patients waiting for surgery. The SSCN is to complete a province-wide list, which includes the name of the surgeon, the hospital, type of surgery and how long the patient has been waiting. Regardless of where patients live or who their surgeon is, patients are rated on scale between 1 and 6 depending on how quickly they should receive surgery.<sup>47</sup>

Recently, the Saskatchewan government announced it would use part of its \$66 million in new federal money to reduce wait lists and to update and replace existing capital equipment. More specifically, the government stated it wanted to reduce wait lists by 75% in fiscal year 2004/05,

spending \$9.3 million to increase the number of elective surgeries in Regina and Saskatoon by 800 to 1,000 over 5 months.<sup>48</sup>

## **Ontario**

### *Wait Time Strategy*

In November 2004, the Ontario government released its Wait Time Strategy stating it would be reducing wait times in five key areas: cancer surgery, cardiac procedures, hip and knee replacements, cataract surgery and MRI/CT exams by December 2006. Funding is to go toward equipment, personnel and infrastructure to increase the number of surgeries performed.

As part of its strategy, expert panels will identify wait list management issues and develop methods for prioritizing patients.<sup>49</sup> Additional funding will be allocated to hospitals as part of the second phase of the strategy. Conditions for 2005/06 funding, however, will include more sophisticated indicators of efficiency, quality and access, and more stringent requirements for accountability.<sup>50</sup>

A May 2006 report from the Institute for Clinical Evaluative Sciences (ICES) shows that from 2002/03 to 2004/05 there has been steady increase in the rates of service for the five key services identified in Ontario's Wait Times Strategy. Despite this, the report notes that increased service rates cannot yet be associated with a reduction in wait times, with the exception of cardiac procedures, which dropped substantially. Additionally, for the first time since 2001/02, median wait times for hip and knee replacements in Ontario did not increase.<sup>51</sup>

### *Cardiac Care Network*

The Cardiac Care Network (CCN) of Ontario is regarded as one of the most effective initiatives in Canada for better managing of wait lists. The CCN coordinates advanced adult cardiac services at 17 Ontario hospitals through a computerized patient registry. The registry tracks more than 75,000 patient procedures per year and is projected to track over 110,000 within 5 years. Urgency rating scores are used to quantify the severity of a patient's illness and assist in prioritizing patients on the list.

### *Cancer Quality Council/Cancer Care Ontario*

In 2004, the Cancer Quality Council of Ontario (CQCO) released a multi-faceted integrated strategy to reduce wait lists for cancer patients. The approach focuses on four areas, including prevention, increasing supply of cancer resources, coordinating access for patients upon diagnosis and using existing resources more efficiently.<sup>52</sup>

Ontario, as part of its 2004 budget, increased resources for cancer care and included funding for ongoing capital development and additional radiation equipment. Most recently the CQCO and Cancer Care Ontario launched a Cancer System Quality Index, a web-based tool for tracking cancer and the quality of cancer services in Ontario. The index, which has 25

indicators, includes measures such as how accessible services are to patients and how long patients have to wait for chemotherapy and radiation therapy.<sup>53</sup>

Recent data show that one year after the release of Ontario's Cancer Plan, median wait times for radiation therapy have decreased by more than a week (5.6 to 4.7 weeks). This decrease is largely attributable to the government's investment in new cancer care centres and equipment according to a 2005 progress report.<sup>54</sup> Data, however, also show that wait times for chemotherapy remain unchanged, as patients in 2005 waited five or more weeks from the time of referral to a medical oncologist to the start of treatment.<sup>55</sup>

#### *Ontario Waiting List Project*

The Ontario Waiting List (OWL) Project develops and evaluates priority rating tools to standardize the process of prioritizing patients awaiting medical services.<sup>56</sup> This project builds on the work of the Western Canada Waiting List (WCWL) and is piloting three of the WCWL tools: MRI, cataract removal surgery and general surgery.<sup>57</sup>

#### *Ontario Joint Replacement Registry*

The Ontario Joint Replacement Registry captures information on hip and knee replacement surgery, including wait times for consultations and surgeries, patient demographics, surgical techniques and environments, and types of replacements used.<sup>58</sup>

#### *Hospital Emergency Department and Ambulance Effectiveness Working Group*

The Hospital Emergency Department and Ambulance Effectiveness Working Group was established to advise the government on ambulance offload times and waits in EDs. In 2005, the Working Group released a report outlining 15 recommendations to reduce congestion at EDs.<sup>59</sup> In response, the Ontario government announced various initiatives to reduce ED waits.

### **Nova Scotia**

#### *Wait List Management System for Orthopaedic Surgery*

In Nova Scotia, a Wait List Management System has been established for orthopaedic surgery in the Capital District Health Authority. A visual analogue scale is used at the time of booking to assign a priority rating for each patient. A forecasting model has also been developed to monitor the wait times and predict which inefficiencies have an impact on patient flow. The database does not yet outline the order of patients waiting for surgery (i.e., no scheduling system).

#### *Provincial Wait Time Monitoring Project Steering Committee*

A Provincial Wait Time Monitoring Project Steering Committee was formed to research and recommend a standardized, province-wide approach to collecting and reporting wait time information. The Steering Committee focused on three areas: surgical services (orthopaedics),

diagnostic services (CT, MRI, etc.) and referrals from GPs to specialists (gastroenterology, plastic surgery and medical oncology).

The recommended target wait times vary among the different service areas. For example, for surgical services Priority “A” patients should receive care in 24 hours or less, while Priority “F” patients may wait more than six months.

A report released by the committee also proposes that a Wait Time Monitoring Advisory Committee be established to provide advice to the Minister of Health. The advisory committee would also communicate with health care providers and the public on wait time issues.<sup>60</sup> Since the publication of the report, the Nova Scotia Department of Health has established a Wait Time Advisory Committee, consisting of sixteen members, including two representatives appointed by the province’s Medical Society. The Committee will identify current wait time pressure points throughout the system and make recommendations to the Minister of Health on ways to reduce long waits.<sup>61</sup>

### **New Brunswick**

In February 2006, the New Brunswick Surgical Care Network was launched, which includes wait times for various types of surgeries by hospital. The New Brunswick government has also developed a surgical access management strategy to improve access and reduce wait times. One of the initiatives is the development of a provincial surgical patient registry that will involve a standardized patient assessment process in each surgical specialty. The Ministry of Health is also establishing target times for surgery that will be implemented once the registry is operational.<sup>62</sup>

### **Manitoba**

In Manitoba, the Wait Time Reduction Plan evolved as a result of a 1998 report released by the Manitoba Centre for Health Policy that provided information about wait times for diagnostic tests at Manitoba hospitals and radiation therapy at CancerCare Manitoba.<sup>63</sup>

February 2003, the provincial government announced that Manitoba would offer funding through the Cardiac Critical Shortages Fund to cardiac patients who have exceeded recommended wait times in order to cover accommodation and travel costs when receiving cardiac surgery outside the province.<sup>64</sup>

As part of its 2005/06 provincial budget, the Manitoba government announced that it would be allocating an additional \$10 million to reduce the number of patients waiting for hip and knee replacements (currently over 1,400).

In October 2005, the Manitoba government announced a \$155 million five-point plan to improve access to quality care and reduce wait times. The plan includes more diagnostic testing; more surgeries; more health professionals; system innovation; better wait list management; as well as prevention and health promotion.<sup>65</sup> As noted on the Manitoba Health website, the additional funding has allowed the province to provide more joint replacement

surgeries and MRIs. In particular, \$57.1 million has been allocated for more surgeries, while \$25.5M from the \$155 million will go towards extra diagnostic tests.<sup>66</sup>

### Quebec

In the recent Supreme Court of Canada case, *Chaoulli v. Quebec (Attorney General)*, the Court found that Quebec's public health insurance legislation prohibiting the purchase of private insurance for publicly insured health services and private payment for hospital services is a violation of the Quebec Charter.<sup>67</sup> In response, the Quebec government announced a plan to introduce care guarantees for specific procedures, particularly hip and knee replacements as well as cataract surgery. Under the proposed plan, patients waiting more than 6 months could be sent for treatment at a public facility in another part of the province, while after 9 months patients could be sent for care out of province, outside of Canada or at a Quebec-based private clinic. In each case the Quebec Ministry of Health would pay the bill. The Quebec government estimates the costs of implementing such a guarantee at \$20 million per year.<sup>68</sup>

### Western Canada Waiting List Project

Along with the individual provincial initiatives to reduce wait times outlined above, there had been significant provincial collaboration to better manage wait lists among the four western provinces through the Western Canada Waiting List (WCWL) Project. This project included a partnership of four medical associations, four ministries of health, seven regional health authorities and four health research centres.

In September 1998, the WCWL Project received \$2.2 million from the federal Health Transition Fund to address significant information gaps in the health care system and to influence the way wait lists are structured, managed and perceived in Canada. Priority was given to the following five clinical areas: total hip and knee replacement, cataract surgery, general surgery, children's mental health and diagnostic MRI.<sup>69</sup> The goal of the WCWL Project was to develop tools that provide a clinically transparent method of prioritizing patients for wait listed services.

Most recently, in February 2005, the WCWL Project released its second major report entitled *Moving Forward*. Combining input from physicians, patients and the public with WCWL scoring systems, the paper proposed maximum waits for hip and knee replacements as well as cataract surgery. For hip and knee replacements the range is 4 weeks for the most urgent patients to 20 weeks for the least urgent. For cataract surgery, the range is 4 weeks for the most urgent to 12 weeks for the least urgent. Along with proposing maximum waits, the WCWL began the development of point-count systems to prioritize referrals from primary care physicians to specialists.

Although never formally implemented, the WCWL wait time work appears to have influenced the wait time benchmarks that First Ministers agreed to in December of 2005 and was undoubtedly the catalyst behind several provincial initiatives to introduce improved waitlist management techniques. Despite this significant progress made by the WCWL, the project was closed on April 1, 2006 due to a lack of funding.

## V. International Scan on Wait List Management

### Overview

Almost every country with a publicly funded health care system experiences challenges with access to services and waiting.<sup>70</sup> Wait times tend to increase in countries that combine public health insurance (with zero or low-cost sharing) and constraints on surgical capacity,<sup>71</sup>. Currently one-half of OECD countries, including Canada, report problems with wait times for elective surgeries.

### Countries with No Recognized Wait Time Problems for Scheduled Procedures

#### Denmark

Over 90% of patients are generally treated within 1 to 2 months. During the 1990s, efforts to introduce a 3-month maximum wait failed, and the government resorted to extra funding-specific targets to reduce wait times for treatments such as heart bypass surgery and angioplasty. In June 2001, the government announced similar funding for cancer treatment.<sup>72</sup>

In July 2002, Denmark announced an initiative to provide patients with the right to choose a private hospital or go abroad if their wait time for elective surgery exceeded 2 months in public hospitals. As part of this guarantee, new funding was provided to increase surgical activity. Between July 2002 and December 2003, the average maximum wait time for 18 key elective procedures decreased by 22%. Surgical activity also increased by 18%.<sup>73</sup>

Authors Clemmesen and Hansen (2003, cited in Siciliani and Hurst, 2003) also found that the move to partial Diagnosis Related Group (DRG) based financing in Danish hospitals has led to increased productivity. DRGs provide a finance and patient classification system using diagnosis, type of treatment, age and other related factors as the screening criteria. Hospitals are then paid a predetermined amount of money for treating patients from a given DRG, regardless of the actual cost of care provided.<sup>74</sup> The study by Clemmesen and Hansen following 18 common surgical procedures found that hospital activity increased by 13% in the year immediately following implementation of DRG funding in 2000. Equally important, average waiting times fell 17%, from 26 weeks to 21.5 weeks.<sup>75</sup>

#### France

France has the highest number of beds per population ratio of any OECD country, with 6.7 acute care beds per 1000 people. France also has 3.3 physicians per 1,000 people, which is almost 60% higher than Canada's ratio.

France's public health expenditure per capita in 2000 was \$1,810, as opposed to \$1,585 in countries with waiting times. An OECD report concludes that the high capacity available in the hospital sector, combined with free access to private hospitals (accounting for 30% of beds) under public health insurance, together with fee-for-service remuneration of the specialists and activity-related funding in private hospitals, explain the absence of significant wait times in the French health care system.<sup>76</sup>



## Germany

Germany's system is a mix of compulsory and voluntary health insurance. According to the World Health Organization, less than 0.5% of its population is uninsured. Minor surgery is provided in the ambulatory sector under fee-for-service arrangements in private practice.<sup>77</sup>

The availability of hospital acute care beds in Germany is among the highest in OECD countries, with 6.4 beds per 1,000 population in 2000. The number of practising physicians per 1,000 population is 3.3, as opposed to 2.8 for countries with wait times. Total and public health expenditure per capita in 2000 were respectively \$2,780 and \$2,086 compared with \$2,092 and \$1,585 in countries with significant wait times.

Germany's universal health insurance, combined with high hospital capacity and extensive ambulatory day surgery (the latter remunerated through fee-for-service), are likely explanations for the lack of significant wait times. In fact, with the exception of transplantations there are virtually no wait lists in Germany.<sup>78</sup>

## Switzerland

Switzerland has a very high availability of equipment, acute care beds and health care providers. For example, Switzerland has 12.9 MRI units per million compared with Canada's approximately 3.5 per million. Switzerland also has 3.9 hospital beds per 1,000 people (22% higher than Canada) and 3.5 physicians per 1,000 people (two-thirds higher than Canada).<sup>79</sup>

## United States

The US spends much more on health care than all other OECD countries.<sup>80</sup> Although bed capacity is lower than in other countries without wait times, day surgery capacity is comparable or higher. Another factor for the lack of wait times in the US is that the majority of surgery is private and there is a highly incentivized system to meet demand through activity-related payments.<sup>81</sup>

## Countries with Recognized Wait Time Problems for Scheduled Procedures

Australia, Ireland, New Zealand, Norway, Spain, Sweden and the UK all have recognized wait time problems for elective surgeries. All of these countries, however, have adopted various measures in an attempt to reduce wait times.

### Australia

In Australia, as in Canada, the management of wait lists is largely the responsibility of state and territory governments. The federal and state/territory governments have recently agreed to performance targets for elective surgery wait times and have apportioned funds to achieve targets.<sup>82</sup>

In 1991, the State of Victoria introduced several policies designed to reduce wait lists including directives for surgeons to better categorize patient need for treatment, hospital funding linked to activity rather than unmet demand, and funding linked specifically to the treatment of

patients on the list. The intention of the last measure was to ensure that as hospitals increased their number of surgeries in response to payment based on activity, they did not allow the lists for routine operations to grow. The impact was a fall in both wait times and the numbers of patients on waiting lists.<sup>83</sup>

In 1995, the National Demonstration Hospital Program was established to reduce clinically inappropriate wait times for elective surgery. Under this initiative, funding was provided directly to hospitals that had developed and implemented best practice models in elective surgery management to work with groups of hospitals seeking to improve their services in similar areas.<sup>84</sup> Several successful strategies were identified, including the introduction of pre-admission and admission services; optimization of patient's health status prior to admission; facilitation of day surgery admissions; optimization of the OR schedule by reducing cancellations on the day of the scheduled surgery; education of patient and family about hospital procedures; and computerization of patient's data.<sup>85</sup>

Other state-level strategies in Australia to reduce wait lists include a central wait list bureau, additional funding for complex procedures, and performance bonuses for hospitals that meet access targets.<sup>86</sup>

### **Ireland**

Wait list problems have been a constant feature of the Irish health care system. This is perhaps due to the 21% decrease in the number of hospital inpatient beds from 1980 to 2000, as well as a concurrent 6% increase in inpatient admissions. During the same period the Irish population also increased by approximately 15% (3.4M to 3.9M). The government has attempted to combat the wait list problem through additional funding and various initiatives. One such initiative is the National Treatment Purchase Fund (NTPF), which has the objective of purchasing treatment in Ireland or abroad for adults who wait one year or more (children 6 months or more) for treatment. To date, it is estimated that over 23,000 patients have been treated through the NTPF, with the majority having received services in private facilities in Ireland and a small number traveling to the UK.<sup>87</sup>

### **New Zealand**

In 1996, the New Zealand National Advisory Committee on Core Health and Disability Services proposed replacing wait lists with a booking system to improve wait times for elective surgery. New Zealand has introduced a maximum wait time for elective surgery of six months accompanied by a booking system for all patients on the wait list. Patients not meeting the criteria for booking are referred back to their GPs. As a result, waits of over six months for elective surgery have virtually disappeared.<sup>88</sup>

To ensure equity in access, New Zealand assigns up to 100 points to patients based on the severity of the patient's condition and on considerations of expected treatment benefit. In the case of coronary artery bypass graft surgery, for example, clinicians agreed that a score of at least 25 was needed before surgery for the patient would be considered. Following

implementation of this initiative, there was a substantial reduction in medical treatment wait lists over two months, over six months and over two years.

However, the success of the initiative is somewhat dependent on a definitional shift rather than real change through increased activity, as wait lists are reduced at the expense of extending wait lists under the care of the GP.<sup>89</sup>

### **Norway**

In Norway, a six-month maximum wait time guarantee for more severe patients was implemented in 1990 but abandoned in 1997 because it did not adequately protect the patients with highest need, particularly those who required the treatment earlier than three months. Moreover, the guarantee was not binding as there were no practical consequences if the guarantee was not met. In 2001, the guarantee was replaced with “the right to necessary health care,” where the patient still has the right to receive the treatment in an “appropriate” time limit, assessed on an individual basis.<sup>90</sup>

### **Spain**

In Spain, between 1996 and 2000, targets were set to reduce average wait times and establish a maximum wait time. Other initiatives included extra funding allocations to hospitals to meet wait time targets, financial compensation to public hospital physicians who chose to work extra time to shorten wait lists, increased role of private hospitals, and an entitlement for patients waiting over six months to choose public or private hospitals.<sup>91</sup>

The strategy of funding allocations to hospitals and compensation to physicians has been effective. By 2000, maximum wait times were down to six months and the mean waiting times were reduced to 55 days. Wait times of patients in 10 communities managed by the central government decreased from 210 days in June of 1996 to 67 days in 2000.<sup>92</sup>

### **Sweden**

In 1991, the Swedish government and its County Councils agreed on a maximum wait time guarantee, which stated that patients who had been waiting for any of 12 designated procedures were to be offered treatment within three months. If the hospital could not offer treatment within the guaranteed time, the patient had a right to be treated in another hospital or by a private clinic at the home hospital’s expense.<sup>93</sup> Under this plan, which was in force from 1992 to 1996, wait times initially reduced, but after two years they started to increase to their original levels.<sup>94</sup>

In 1996 a revised guarantee was introduced that focused on setting maximum wait times for first contact with GPs and outpatient visits to specialists. Then in 2003, a new national treatment guarantee was agreed to. The guarantee is based on the “0-7-90-90” rule, meaning instant contact with the health care system, seeing a GP within 7 days, consulting a specialist within 90 days and waiting no more than 90 days after being diagnosed to get treatment.<sup>95</sup>

Along with the care guarantee, the use of service-based funding has also proven to be effective in reducing wait times in Stockholm County. The Stockholm County Council experienced an 8% increase in inpatient care, a 50% increase in day surgeries, a 15% increase in out-patient visits, and an 11% increase in overall surgical activity after the move to diagnosis-related group payments. Along with these increases, total costs also fell by 1%.<sup>96</sup>

### United Kingdom

In the late 1980s, the UK introduced the Waiting List Initiative to eliminate waits exceeding two years. In 1991 the Conservative government introduced a Patient Charter, which set out a number of National Health Service (NHS) rights and standards that the NHS was expected to meet. One of these rights was that patients be guaranteed admission to treatment within two years after being placed on a waiting list. It is important to note, however, that these charter standards and rights were not enforceable through the legal system.<sup>97</sup> This guarantee was revised in 1995 to ensure access to all hospital-based services within 18 months and to cardiac services within 12 months.<sup>98</sup> A guarantee of six months on out-patient wait time was also added.<sup>99</sup>

By March 2000, the number of people waiting for hospital treatment was reduced by 100,000. Although waits over 18 months were virtually eliminated, approximately 50,000 people were still waiting over 12 months. Thus, despite the numbers of people waiting for treatment falling between 1997 and 1999, the numbers waiting over three months rose sharply.<sup>100</sup> In February of 2006, the government announced that the National Health Service (NHS) had achieved the target of delivering a maximum wait of six months for treatment.<sup>101</sup>

Despite these successes, a 2005 report from the National Audit Office shows that more than 40% of patients suspected of having cancer were not being seen by a specialist within two weeks. Analysts have also commented that the UK's wait time guarantees are inefficient by arguing that some patients with more minor ailments are treated before others with more serious conditions in order to meet the guaranteed maximum wait time for all patients.<sup>102</sup>

Other specific UK initiatives to reduce wait lists include the following:

- Fundholding, introduced in 1991, gave some family doctors budgets to purchase a range of services for their patients, including routine hospital procedures. Results from studies show the impact on patient wait times are the same or better.<sup>103, 104</sup>
- Since 2001, the Performance Fund has provided financial rewards to both hospital trusts and Primary Care Trusts (PCTs) that reduce wait times.<sup>105</sup>
- Activity-based funding for hospitals was introduced in 2003. Currently, most Primary Care Trusts now pay hospitals based on historic cost levels but are more frequently funding hospitals based on activity levels.<sup>106</sup>
- Approximately 30 NHS treatment centres, dedicated exclusively to elective surgery and diagnostic tests, have opened since April 2002. The treatment centres have tended to concentrate on procedures with the highest wait times for treatment including orthopaedics and ophthalmology.<sup>107</sup>

- In 2000, the UK government signed a concordat with private providers to enable publicly funded patients requiring intensive care or elective surgeries to receive them in private hospitals. Recently, the NHS stated that by 2006 the independent sector will carry out up to 15% of surgical procedures for NHS patients.<sup>108</sup> In 2005, the NHS announced that it will more than double the number of operations it commissions in the private sector to help meet government wait time targets.<sup>109</sup>

Despite considerable cash infusions to the UK health care system over the past few years, the NHS is facing significant resource shortages and an apparent funding crisis. For example, so far Primary Care Trusts in 2006 have recorded total deficits of £700 million and in the previous two months more than 7,000 health care workers have been laid off.<sup>110</sup> In fact, since the end of May 2006, hospital job cutbacks within the NHS have averaged more than 1,000 per week as administrators attempt to meet budget targets.<sup>111</sup> Furthermore, although the government has doubled its investment to the NHS from £44.7 billion in 1997 to £82.5 billion in 2005, the UK faces various resource challenges including a shortage of physicians. In 2003, for example, the UK had 2.2 practising physicians per 1,000 population which although an increase from 1.9 per 1,000 in 1998, is still well below the OECD average of 2.9.<sup>112</sup>

## VI. Recommendations for Reducing Waits in British Columbia

Simply put, excessive wait times can prolong suffering and needlessly put patient lives at risk. As the Supreme Court of Canada noted in the recent *Chaoulli* decision, “delays in the public health care system are widespread and in some serious cases, patients die as a result of waiting lists for public health care.”

The management and reduction of wait lists should not be just on the five priority areas identified by the First Ministers (i.e., sight restoration, cancer care, cardiac care, joint replacements and diagnostics). Although these are all important areas, it is critical that waits for other procedures or areas of the health care system not be ignored. This sentiment is seen in a recent survey of members of the Association of Canadian Academic Healthcare Organizations (ACAHO) which raised concerns that a relentless focus on only the five priority areas could have a negative impact by minimizing investments required in other areas of the health care system.<sup>113</sup> This is also one of the reasons why the BC Provincial Surgical Services Project (PSSP) was established.

The fundamental purpose of this paper is to explore means to reduce *all* waits in all areas of the health care system. This includes waits to see a GP or specialist, waits in EDs and waits for post-acute care including rehabilitation, home care and long-term care. New data from the Canadian Institute for Health Information (CIHI) show that waiting for a specialist makes up a significant proportion of the overall waiting period for care. For example, in the case of hip and knee replacement patients, nearly one-third (30%) of the time between referral to a specialist and surgery was spent waiting for an initial visit to the orthopaedic surgeon. Another 10% of the time went by before the decision was made to have surgery.<sup>114</sup> CIHI data also show that wait times tend to be longest for knee replacements, followed by hip replacements and cataract surgery.

But the wait list problem in BC is more than a problem of waiting for specific procedures such as a hip or knee replacements; it is a problem faced in every area of the health care system. This problem over time will worsen unless immediate action is taken.

Based on the evidence provided in the previous sections, the BCMA is presenting 29 recommendations to reduce and better manage wait lists in BC. The recommendations are outlined in five sections:

1. Building capacity
2. Establishing wait time benchmarks for diagnostic, therapeutic and surgical services
3. Developing and implementing wait list management tools
4. Improving accountability
5. Funding

### Building Capacity

BC's lack of capacity in the acute care system is highlighted by the serious shortage of acute and long-term care beds, under-utilized operating rooms, and a lack of access to diagnostic equipment.

## Acute and Long-term Care Beds

An OECD report notes that those countries not reporting wait times had on average 66% more acute care beds (per 1,000 population) compared with countries reporting wait times. In 1998, for example, the average number of acute care beds was 5.8 per 1,000 population for those countries not reporting significant wait times as opposed to 3.5 per 1,000 population for countries reporting wait times. BC is well below both rates at 1.7 beds per 1,000 population.<sup>115</sup>

One of the most pronounced changes during the 1990s was the significant pressure to reduce costs in the acute care sector. As budget pressures increased, governments turned to the sector which consumed the majority of public dollars – the acute care system and its hospitals. BC was no exception, and throughout the 1990s there was a steady reduction in the number of acute care beds in the province. Further, from March 2002 to March 2004, an additional 1,279 hospital beds were closed – a 19% reduction in capacity when population increases in BC over the same time period are taken into account.<sup>116</sup>

Reductions to long-term care beds also increase pressures on the acute care system as more people residing in acute care beds wait to be placed in long-term care. In *Turning the Tide: A New Course for Health Care* (2001), the BCMA stated that 2,000 long-term care beds were immediately required and that up to 10,000 would be needed over the course of the next 15 years. Assisted living, as advocated by the BC government, is not an adequate solution to the shortage of long-term care beds. Assisted living is more of a housing model in which people live somewhat independently, are provided sheltered accommodation and require a minimum set of aids to daily living. Most patients currently in hospitals that require long-term care have much heavier levels of care and cannot be accommodated in assisted living situations.

Currently, BC has insufficient capacity to meet current bed demands, let alone the increased demand coming in the near future. As the number of people over age 65 increases, BC will require more capacity. By 2021 it is projected there will be more than one million seniors in BC, and of these more than 120,000 will be over 85.<sup>117</sup>

Many regions across BC already have significant waits for people requiring publicly funded long-term care, a problem exacerbated by changes to criteria for qualifying for a long-term care bed. In the 2004 National Physician Survey, 64% of BC physicians rated patient access to long-term care beds as either fair (25%) or poor (39%). The Canadian Centre for Policy Alternatives recently found that access to long-term care and home health services for BC seniors has decreased significantly over the past three years.<sup>118</sup> For example:

- There has been a net decrease of 1,464 long-term care beds since 2001, even after accounting for new assisted living units (ALUs). (Between 2001 and December 2004, BC cut 2529 residential care beds and added only 1,065 ALUs.)
- Along with New Brunswick, BC has the lowest level of access to residential care beds in Canada for seniors aged 75 and over, falling 13% below the national average.
- Relative to the population of BC seniors aged 75 and over, there has been a 13% decline as of 2003 in home support hours.

Adequate home care programs, designed to assist patients to recuperate outside of hospital and to live more comfortably in their own residences, have not materialized. It is estimated that the average annual cost to government for people with moderate care needs living at home is \$9,624, while the cost for the same person in a health institution is almost three times as much at \$25,742.<sup>119</sup>

As part of the 2003 First Ministers Accord on Health Renewal, a number of commitments were made with regard to home care. These included 1) determining by September 30, 2003, the minimum level of home care services to be provided and 2) providing first dollar coverage for this basket of services for short-term acute home care, including acute community mental health and end-of-life care.<sup>120</sup> Unfortunately, governments have not met either of these goals.

In summary, adequate home care and long-term care must be available across BC. Having adequate systems in place will ensure that patients receive appropriate care once discharged from hospitals. More importantly, adequate systems will put less pressure on the acute care system, which in turn will help reduce wait lists. For example, it is estimated that ten percent of hospital beds are occupied by patients who would be better served in nursing homes, convalescent care or at home with appropriate community supports.<sup>121</sup>

British studies have shown that ED overcrowding rarely occurs when bed occupancy rates approach 85%, but consistently occurs when occupancy is greater than 90%. A British Medical Association report has noted that the single most important way to improve wait times in accident and EDs is by increasing the availability of inpatient beds, and that keeping bed occupancy below 85% in hospitals will prevent long waits for admission as well as the cancellation of elective surgery.<sup>122</sup>

On average, most hospitals in Canada, including those in BC, currently operate on 95% bed occupancy rates,<sup>123</sup> which is why we recommend that to avoid overcrowding the BC Ministry of Health and the Health Authorities commit to maintaining a routine acute care bed capacity level not exceeding 85% in hospitals. This level, which will allow hospitals to deal with unexpected demand, should be outlined as part of the Ministry of Health Performance Agreements with the Health Authorities. As of March 2004, there were approximately 7,311 acute care beds in BC. Assuming an average occupancy rate of 95%, this means that close to 6,945 beds are currently in use. To obtain this figure but at an 85% occupancy level would require approximately 8,171 beds or an additional 860 beds province-wide. At an estimated cost of \$411 per acute care bed per day, this would equate to approximately \$130 million in additional funding per year.

In its *New Era Document*, published prior to the 2001 provincial election, the BC Liberal government pledged to build an additional 5,000 long-term care beds by 2006. Therefore, we advocate that the provincial government commit to this election promise.<sup>124</sup> As of December 2004, there were 22,891 residential care beds. An increase of 5,000 would equate to a total of 28,000 long-term care beds for BC. At a cost of \$140 per long-term care bed per day this would equal approximately \$255 million per year. The cost of implementing new acute and long-term care beds will be significant. The BCMA, therefore, recommends that an additional



funding of \$385 million per year be designated to fund the implementation and maintenance of new acute and long-term care beds across the province. Along with increasing bed capacity, where appropriate, strategies should also be undertaken to improve the utilization of acute and long-term care beds. This, for example, could include reducing average length of stays in hospitals that do not have an adverse effect on patient outcomes or the quality of care received.

**Recommendation #1**

***The BC government and Health Authorities commit to maintaining a routine acute care bed capacity level not exceeding 85% in hospitals.***

**Recommendation #2**

***The BC government fulfill its commitment to increase the number of long-term care beds by 5,000 by the year 2010.***

**Operating Room Capacity**

The Canadian Orthopaedic Association recently noted that restricted OR time means less than half of Canada's practising orthopaedic surgeons are able to work at full capacity, and that over 5,000 additional operating hours per 100,000 population per year are required to adequately service the Canadian population.<sup>125</sup> On a per capita basis, this amounts to over 200,000 additional operating hours per year in BC for orthopaedic surgeries. According to 2005 CMA physician supply data this would equate to almost 1,150 extra OR hours on average per year for each of the 175 active orthopaedic surgeons in BC.

The BCMA believes that one of the best ways to reduce wait times for many surgical procedures is to increase existing unused capacity in the public system. BCMA data show that almost all hospitals report lengthy wait times for eye and orthopaedic surgeries despite having unused daytime and evening OR capacity. In 2003, most ophthalmologists and orthopaedic surgeons reported a decrease in their available OR time over the previous five years. These physicians also attributed the lack of OR time to insufficient funds and a shortage of professional staff including registered nurses.<sup>126</sup>

A 2004 province-wide survey of hospitals conducted by the BC Nurses Union (BCNU) shows that in almost every hospital, ORs are used far less than their capacity, few elective surgeries are done after 3:30 p.m., and operating rooms are routinely shut down for budgetary reasons when they could be used to treat patients on wait lists.<sup>127</sup>

Along with decreasing waits for surgeries, increased OR time will help keep the skill level of physicians up to date by providing a minimum amount of OR time per week. Research shows that the more times physicians perform a particular procedure, the more proficient they become at it.<sup>128</sup>

In an attempt to shorten current wait lists, the BCMA advocates that the provincial government and Health Authorities increase operating room capacity by a minimum of 25% within the next two years and implement a strategy to see another 25% expansion realized by 2009/10.<sup>129</sup> The costs of this increase will be significant, and therefore, the BCMA recommends that a minimum of \$100 million be allocated for such purposes over the next two years. Along with increased funding, further studies should also be undertaken to more accurately forecast future OR capacity requirements in order to meet the needs of a growing and aging population. Over time, a predictable level of OR capacity should be established based on societal needs and with regard to any efficiencies into the system.

### **Recommendation #3**

***The BC government and Health Authorities increase operating room capacity by at least 25% within the next 2 years and implement a strategy to see a further 25% expansion realized by 2009/10.***

Along with expanding capacity, existing resources, including ORs, must be used more efficiently. For example, a recent study of Ontario hospitals noted that even a conservative growth in weekend service (i.e., weekend days at 50% of average weekday capacity) can achieve an increase in procedure volume close to 15%.<sup>130</sup> Such figures are likely to apply to BC as many ORs are not being utilized as much as they could be.

Finding ways to improve efficiencies within hospitals, particularly ORs, should be one of the goals of a program to identify best practices to reduce wait times (see the section on Evidenced-based Clinical Guidelines and Best Practices, below).

### **Diagnostic Equipment**

A major reason for delays in receiving access to timely medical care in Canada is a lack of diagnostic equipment. In a 2002 survey, 61% of Canadians reported that waiting times for diagnostic tests seemed worse than they were five years ago.<sup>131</sup> More recently, a Statistics Canada survey showed that of the 2.1 million Canadians who received diagnostic tests in 2005, 15% or 315,000 reported having trouble accessing such care including waiting too long to get an MRI or CT scan.<sup>132</sup> To help address this issue, the federal government in 2000 established a two-year, \$1 billion Medical Equipment Fund to assist provinces and territories to purchase and install equipment. BC's portion of the 2000 Medical Equipment Fund was approximately \$132 million. Further, on February 5, 2003, Canada's First Ministers agreed to a new Health Care Action Plan. Of the \$34.8 billion provided by the federal government over five years, \$1.5 billion went toward a three-year (2003/04 to 2005/06) Diagnostic and Medical Equipment Fund. BC's portion of this fund was approximately \$200 million.

The new federal funding has helped increase the numbers of medical equipment in Canada and BC.<sup>133</sup> Despite the new additions, however, Canada and BC continue to rank below most OECD countries in the number of MRI and CT scanners per million population. For example,

according to a recent report by the Canadian Institute for Health Information (CIHI), Canada ranked 13<sup>th</sup> among the 22 OECD countries with 4.7 MRI scanners per million. Canada also placed 17<sup>th</sup> among 21 OECD countries in CT scanners, with 10.3 per million population. As of January 2004, BC had 4.6 MRI per million population, which was below the rates in Alberta, Quebec, New Brunswick and PEI. Except for Ontario and Alberta, all provinces ranked higher than BC in the number of CT scanners per million population, which has 10.8 per million population. It is important to note, however, that while Canada has fewer diagnostic machines per million people, it uses MRI and CT scanners more intensively than nations such as the US and the UK.<sup>134</sup>

In 2000, Canada ranked last among 28 countries in the number of PET scanners, a leading diagnostic tool in most countries.<sup>135</sup> One of the major barriers to the wider use of PET scanners is the lack of reimbursement for PET scanning. On a positive note, BC, Alberta and Quebec have begun reimbursing costs associated with PET scanning. Currently, however, there are only 12 PET scanners in Canada including two in private clinics in Quebec and BC. Of the remaining ten, only three are available for clinical use while the others are used primarily for research. Quebec, however, recently announced that it will acquire ten more PET scanners by 2007, bringing their total number to 14.<sup>136</sup> This is well above the number currently in BC.

Under the current health care system, the operation of machinery such as CT scans or MRIs is funded through global hospital budgets. This type of funding creates a perverse incentive for hospitals not to obtain and/or use such equipment, as the costs of doing so are quite high and have an impact on the hospital's overall budget. The presence of a technical or operational fee, which rewards hospitals and/or physicians for the use of such equipment, would provide a greater incentive for facilities to implement and use these technologies.

Along with increasing the quantity of diagnostic equipment, it is critical that it be used appropriately. Physicians in British Columbia often face a catch-22 for MRIs: surgeons will not see patients before an MRI is taken, but MRIs will not be taken until the patient has been seen by a surgeon, a situation that can limit appropriate access to this technology. Conversely, Canadians are subjected to an estimated 3.5 million unnecessary diagnostic tests which cost the health care system approximately \$500 million annually. Identified causes for this include tests being repeated because the original results are unavailable and patient pressure to order tests.<sup>137</sup> Some of these factors could be mitigated by the increased access to appropriate clinical guidelines and the use of computer applications.<sup>138</sup>

The BCMA, therefore, recommends that the provincial government, in conjunction with practising physicians, form a task force to develop strategies for increasing the availability and appropriate use of diagnostic equipment.<sup>139</sup> Such strategies could include adopting new funding mechanisms and/or incentives to encourage hospitals to adopt and use diagnostic equipment. The task force should have equal representation from the BC government, Health Authorities and the BCMA and report no later than March 31, 2007.

**Recommendation #4**

***The provincial government, in conjunction with practising physicians, form a task force to develop strategies for increasing the availability and appropriate use of diagnostic equipment. The task force should have equal representation from the BC government, Health Authorities and the BCMA and report no later than March 31, 2007.***

**Emergency Care**

In BC, more than half of all surgeries are identified and performed by physicians as emergency procedures. In the health care system, emergency cases have priority over elective procedures. On average, 70% of patient days in hospitals are devoted to emergency care.<sup>140</sup>

As highlighted in a report by the Wait Time Alliance, excessive wait times for emergency care are not unique to BC but are widespread across Canada. The report, for example, states:

- 74% of Canadians have indicated that they are concerned about prolonged (ED) waits and deteriorating service.
- Overcrowding is the most serious issue facing Canada's EDs.
- Over the past decade, Canada has seen a 40% decrease in overall hospital bed capacity due to government funding cuts.
- Most hospitals in Canada currently operate on 95% bed occupancy rates.
- Medically acceptable wait times in Canadian EDs have been defined by the Canadian Triage and Acuity Scale (CTAS).<sup>141</sup>

Unlike provinces such as Ontario, BC does not have a long-term strategy to deal with overcrowding and lengthy waits in EDs. Ontario, for example, in January 2006, announced a \$96 million plan to reduce ED waits including:

- \$29.4 million to create critical care response teams (CCRTs) across Ontario, which consist of intensive care physicians, intensive care nurses and respiratory therapists who are available 24/7 to provide critical care.
- \$38.3 million to open more adult ICU beds and chronic assisted ventilatory care.
- \$10 million to provide critical care training to 450 nurses per year, increase the number of training spots for intensive care doctors by ten, support CCRTs, train community hospital physicians in advanced resuscitation techniques and fund staff retention programs.
- \$12.2 million to support related initiatives, including the establishment of a performance measurement system, the development of a policy to address ethical issues related to critical care access and a series of quality improvement initiatives.<sup>142</sup>

In contrast to Ontario, in BC the Provincial Emergency Services Project (PESP) was launched in November 2002 in an attempt to improve access to, and the effectiveness of, BC's emergency health services system. A progress report released in April 2003 noted that the

current approaches to the management of emergency and elective care are not effective in addressing and preventing capacity problems. The same report highlighted some of the major problems facing ERs including nursing staff shortages, specialist shortages, overcrowding in the ED and inter-hospital transfer. The report provided a number of short-term recommendations including the following:

- Health Authorities should develop better information that contributes to better performance (e.g., create a plan for a province-wide information management program for EDs)
- A senior executive should lead system-wide planning for emergency services within each Health Authority
- Health Authorities should develop systematic approaches to coordinate and manage access to inpatient and diagnostic resources.
- Health Authorities should improve outcomes and access through better coordination in planning community services.<sup>143</sup>

It is not clear whether these recommendations have been implemented, as no further progress reports have been released. Despite these recommendations, however, emergency wait times in British Columbia have worsened. Evidence of this is seen from recent reports from doctors at VGH and Royal Columbian Hospital (RCH) describing conditions within their ERs. A document submitted by RCH doctors to the Fraser Health Authority (FHA) notes that at least once daily the ED at RCH cannot handle the influx and has no consistent strategy to effectively handle the flow of patients. The document further states that the FHA's 12 EDs are not meeting demands and cites problems such as bed shortages and health care provider shortages.<sup>144</sup>

According to recent data supplied by Vancouver Coastal Health (VCH) and FHA, ER patients with potentially life-threatening health problems such as chest pains or head injuries are waiting up to an hour and a half to see a doctor at Lower Mainland hospitals. This is six times longer than national guidelines (i.e. Canadian Triage and Acuity Scale), which recommend that any patient with a condition that may threaten life or limb (Level 2) be seen within 15 minutes of being classified by a nurse. More specifically, the data found that only two of 17 hospitals had median waiting times at or below that level, with the longest waits close to 1.5 hours.<sup>145</sup>

Other recent data finds that a significant portion of patients face lengthy ER waits before being admitted to a hospital bed. According to recent Ministry of Health data, between 32% and 45% of patients within ten hospitals in BC for which data was provided are waiting more than ten hours from the time of ER visit to being admitted to a hospital bed.<sup>146</sup>

In a 2006 Canadian study of ER overcrowding by the Canadian Agency for Drugs and Technologies in Health (CADTH), 82% of ER directors in BC said that overcrowding was a major problem in 2004/2005, which was considerably higher than the national average of 62%.<sup>147</sup> Some of the other results from this study found that:

- More than half of ED directors stated that ED overcrowding impacted the quality and accessibility of emergency care. In particular, 82% stated ED overcrowding increases stress among nurses (65% for physicians), while 79% said it increases ED wait times.
- 85% of ED directors thought the lack of available beds for admitted patients was a major cause of ED overcrowding. Other major causes cited included lack of acute care beds (73%), ED length of stay for admitted patients (62%), increased complexity or acuity of patient symptoms (54%) and occupancy rate of ED stretchers (52%).
- Overcrowding is more likely to occur in an ED with over 50,000 visits annually and in communities with a population of at least 150,000.
- Although 54% of ED directors reported that their hospitals have policies to deal with ED overcrowding, 67% stated that they have little or no effect.<sup>148</sup>

In response to recent concerns regarding ED waits, the BC Ministry of Health announced in April 2006 that it would provide an additional \$7 million in one-time funding to reduce existing ED pressures. The funding, which will be allocated to 15 hospitals across BC, will be used for various improvements such as purchasing medical equipment, expediting medical tests or changing the way paramedics transfer patients to ER staff.<sup>149</sup> Advisory teams, consisting of health care professionals including physicians, a nurse and senior health authority representative, will be formed at each hospital to develop solutions and recommend how to allocate the new funding.

Although the BCMA welcomes the new funding, it is important to ensure that the funding be allocated appropriately and that long-term funding and solutions be developed to address the issue. For example, in April 2006 the Canadian Association of Emergency Physicians (CAEP) called on the BC government to establish a task force of emergency experts, similar to what has happened in Ontario, to address the barriers to emergency patient care in the province.<sup>150</sup>

The BCMA advocates that the issue of emergency waits in the province be given top priority. Along with reviewing the current role of the PESP, this will require supporting the new multidisciplinary advisory teams in identifying solutions and in ensuring that funding is allocated appropriately. An ongoing evaluation of the teams through some joint process or dialogue between the government and the BCMA will also be critical. Particularly important is to ensure that the solutions identified by the teams are acted upon. Any joint process or committee should also explore long-term strategies that will reduce wait times and existing pressures within EDs. To accomplish this, initiatives – such as those in Ontario – should be explored for adoption as part of an overall strategy for reducing wait times in EDs.

**Recommendation #5**

***As an immediate priority, the BC government, BCMA and Health Authorities support a multidisciplinary approach, with a neutral chair, aimed at reducing Emergency Department (ED) waits and ensuring new funding is allocated appropriately. Long-term strategies to reduce ED waits province-wide should also be explored jointly by the BC government, BCMA and Health Authorities.***

**Increase Supply of Physicians and Other Health Care Professionals**

According to a survey from the Commonwealth Fund, over 25% of hospital executives in Canada reported serious shortages of pharmacists, nurses and specialists. Hospitals in Canada were significantly more likely than those in Australia, New Zealand and the US to report a serious shortage of specialists. Over 25% of hospital executives reported that at least 10% of scheduled surgeries or procedures were cancelled due to staff shortages or a lack of capacity.<sup>151</sup>

Having a good supply of physicians is important to ensure wait times are reduced and managed appropriately. Countries not reporting significant wait times had on average 13.4% and 23.4% more practising physicians and practising specialists, respectively.<sup>152</sup> As well, it has been reported that an increase of 0.1 practising physicians per 1,000 population is linked to a reduction of median waiting times of 7.6 days across all surgical procedures.

As part of the 10-Year Plan to Strengthen Health, in September 2004, First Ministers committed their governments to develop health human resource action plans. In these plans, federal, provincial and territorial governments agreed to increase the supply of health professionals, based on their assessment of the gaps, and to make their action plans public, including targets for the training, recruitment and retention of professionals by December 31, 2005. To date, BC has yet to release any health human resource action plan.

BC has not developed a provincial physician supply plan since 1997. This is despite commitments made by the provincial government in the previous Master Agreement with the BCMA, which outlines the creation of a Physician Resource Planning Committee (PRPC) to annually review and update a physician resource template and examine the issue of the physician resource needs facing the province now and within the next five years. The PRPC has been defunct since 2001. The regional Health Authorities, with the exception of the Interior and Northern Health Authority, have made little progress in this area, and there is no provincial coordination of effort. We recommend that the BC government, in cooperation with the BCMA and Health Authorities, reconstitute the dormant PRPC to develop a five year provincial physician supply plan no later than March 31, 2007.

**Recommendation #6**

***The BC government and the Health Authorities, with the cooperation of the BCMA, reconstitute the dormant Physician Resource Planning Committee to develop a five year provincial physician supply plan no later than March 31, 2007.***

**Health Care Provider Shortages**

BC and Canada have a shortage of other health care professionals that has resulted in lengthier waits for care. Between 1994 and 2001, the number of RNs in BC per 10,000 residents declined from 74 to 68 (a decrease of almost 8%). This is the lowest nurse-to-population ratio in Canada. The OECD also predicts that by 2016, Canada will have the worst shortage of nurses of all OECD nations, with a shortfall of up to 31% compared with demand.<sup>153</sup>

The decrease in hospital beds outlined earlier and reduced length of stays may account for part of the decline in RNs in BC. According to CIHI data, however, there has also been an increase in the number of LPNs. Between 2002 and 2004, for example, the number of LPNs employed in practical nursing increased by approximately 12% (4,262 to 4,811). Despite this increase, however, the number of LPNs working in hospitals declined from 2,639 to 2,520 as many went to practice in community settings including nursing homes and long-term care facilities.<sup>154</sup> Another report from CIHI, shows that although there have been some recent increases in the number of RNs in BC (27,730 in 2002 to 28,289 in 2004), there has been a similar decline among those working in hospitals (i.e. 17,922 in 2000 and 17,664 in 2004).<sup>155</sup>

One recent study found that increasing the number of RNs in hospitals could reduce costs and improve patient care by avoiding unnecessary deaths and reducing the average length of stay. Specifically, the study found that increasing the use of RNs and hours of nursing care per patient could help avoid more than 6,700 patient deaths in US hospitals and reduce hospital stays by approximately 4 million days.<sup>156</sup>

Although more RNs are required, it is important to note that similar to physicians there is a global shortage of nurses. A 2004 report by the International Council of Nurses highlights the nursing shortages facing most countries. For example, the report notes that many countries, particularly in Africa, Asia and Central/South America, are struggling to provide a minimum level of nurse staffing.<sup>157</sup>

While there has been an increase in the supply of new imaging equipment in the last decade, the supply of medical imaging professionals per 100,000 population has remained constant. In 2003, the rate of medical radiation technologists was 49 per 100,000 population, while the rates of medical physicists and diagnostic radiology physicians remained at six per 100,000 and one per 100,000 respectively.<sup>158</sup>



Due to the deficient supply of various health care providers, the BCMA recommends that the BC government ensure that the province has a sufficient supply of allied health professionals as part of a provincial health human resource strategy to meet patient needs and to reduce wait times.

### **Physician Assistants**

One possibility to help meet existing health human resources challenges could be the introduction of physician assistants. A report from the Canadian Orthopaedic Association (COA) recommends incorporating physician assistants into orthopaedic practice to help relieve surgeons of work such as putting on casts and duties that may not require a physician. The COA states that this will give surgeons more time for referral appointments and surgeries, thereby helping to reduce wait times.<sup>159</sup>

Physician assistants are already used in the Canadian military and are widely used in the US where they interview and examine patients, present the patient and findings to the surgeon, discuss the treatment with the surgeon, arrange the booking of any surgery required and attend and scrub during the surgery.<sup>160</sup> In May of 2006, the Ontario government announced as parts of its HealthForce Strategy in which it is investing \$45 million in 2006/2007, that it would establish new health care professional roles for areas of high need including Physician Assistants. These PAs would assist supervising physicians to deliver medical services such as conducting patient interviews, histories, physical examinations; performing selected diagnostic and therapeutic interventions; ordering and interpreting patient laboratory and radiological results; and counseling patients on preventative health care.<sup>161</sup>

In an attempt to meet existing health human resource challenges, the BCMA also advocates that the provincial government work towards the introduction of Physician Assistants within BC's health care system. It is important to recognize, as stated by the Ontario Medical Association, that the introduction of physician assistants will not resolve the shortage of physicians in the near term. Issues around liability and remuneration of Physician Assistants practising in collaborative models will also have to be addressed.<sup>162</sup>

#### ***Recommendation #7***

***The BC government, in conjunction with the BCMA, work toward the introduction of physician assistants within the health care system.***

### **Specialty Clinics**

As care and technology has advanced, there has been increasing pressure on the health care system to provide the best available care in all areas of the country. BC, for example, has already reached the point where certain types of specialty services are not universally or readily available. The problem will worsen with the shortage of specialists and the high cost of

technology. Therefore, alternative approaches to delivering and receiving care are required and inevitable.<sup>163</sup>

One approach is to design health delivery systems built around a series of specialty clinics that would focus on delivering high volumes of specific procedures such as cataract surgery or joint replacements. This approach would support the finding that the more frequently the same procedure is performed, the higher the quality of outcomes.<sup>164</sup> Recent information from the Canadian Institute for Health Information (CIHI) supports the idea that high-volume facilities (i.e., specialty clinics) can produce better outcomes.

An example of a specialty clinic is an orthopaedic care clinic, where patients could see a GP, have diagnostic tests, be provided physiotherapy support and even have hip or knee surgery done. Such a centre already exists in Winnipeg with the Pan-Am Clinic, which includes a physiotherapy facility, diagnostic centre and not-for-admission surgery. This clinic, which provides over 5,000 orthopaedic procedures annually, is also used as a training facility for medical students. Another example is the Trillium Health Centre in Toronto. Currently, this centre is North America's largest freestanding day surgery facility with eight operating rooms. The surgery centre performs nearly 20,000 procedures per year including 3,500 cataract surgeries.<sup>165</sup>

More recently, the success of such specialty clinics has occurred in Alberta as part of its Hip and Knee Replacement Project. An interim report found that, during the first eight months of this project, new central assessment clinics have reduced wait times. For example, the time for the first orthopaedic consult decreased from 35 to 6 weeks while the time from first consult to surgery declined from 47 to 4.7 weeks. The new process includes the introduction of central assessment clinics, where patients who may require orthopaedic surgery are examined by a team of health professionals in one visit. Recently, as outlined earlier, Alberta is investing an additional \$54 million to continue the hip and knee project and expand the model to other areas including cardiac care as well as breast and prostate cancer.

The Quebec government, as part of its pledge to introduce care guarantees, is also looking at private clinics affiliated with hospitals to do specialized hip, knee and cataract surgeries. The Quebec Minister of Health states that between three and five of these clinics will be set up in key centres of the province. If hospitals fail to treat hip, knee and cataract patients within six months, these facilities will be used to ensure timely treatment at no cost to the patient.

The BCMA believes that under the right conditions similar centres should be developed for other areas including the remaining priority areas of sight restoration, cardiac care, cancer care and diagnostics. These centres, where appropriate, could be part of a hospital or be a separate entity. It is, however, critical to ensure that such clinics be properly evaluated and that practising physicians have adequate input into their development. The BCMA therefore suggests that an additional \$100 million be allocated over the next three years to support the development of such specialty clinics. The \$100 million is based on extending the idea UBC Surgical Innovation Centre for Hips and Knees – which is receiving \$25 million – to the four other priority procedures, i.e., cardiac, cataract, diagnostics and cancer.

The BCMA believes that centres that specialize in selected elective surgeries should be established province-wide, where appropriate, in an attempt to improve quality of care and reduce wait times in BC. The development of specialty clinics should be part of the development of a provincial services plan to coordinate the most efficient access to scarce treatment and diagnostic services. As outlined in the 2006 Letter of Agreement (LOA) between the BCMA and government, a tri-partite Specialty Services Committee (SSC) will be created to improve the quality and access to specialty care. One of the main roles of the SSC could be development of Specialty Clinics along with other initiatives to improve access to care.

**Recommendation #8**

***The BC government facilitate the creation and comprehensive clinical evaluation of Specialty Clinics to increase acute care capacity.***

**Role of the Private Sector: Public-Private Partnerships and Contracting Out**

A public-private partnership (P3) is a contractual arrangement between a public payor and a private provider that obligates the private provider to deliver a certain level of services, under specified terms, in exchange for public financing.<sup>166</sup> There are some advantages to having the private sector involved in the delivery of health care services: private clinics can upgrade technology more rapidly than public hospitals that are subject to lengthy government approval processes, and private clinics can also specialize in specific procedures, which can mean faster turnaround in the OR.<sup>167</sup>

In BC, most of the major P3s currently underway involve the contracting of a health authority or government with a third party for the construction and maintenance of health care facilities. Such recent examples include the Academic Ambulatory Care Centre in VCH and the Abbotsford Regional Hospital and Cancer Care Centre. In these cases a private sector partner has been contracted for the financing, construction and maintenance of facilities. These projects, however, do not involve the contracting out of clinical services to a private provider. In some cases, however, as recently announced by the Vancouver Island Health Authority (VIHA), Health Authorities are proceeding to contract out surgical services. In May of 2006, for example, VIHA issued an RFP for the provision of specific surgical services over a five-year period. The RFP notes that VIHA is seeking to establish long-term relationships with private surgical centres in order to expand surgical capacity. Overall, this could result in the thousands of publicly funded surgical procedures being contracted out to private clinics.<sup>168</sup>

The Canadian health care system uses many private facilities to deliver publicly funded services. Examples include physician offices, diagnostic centres, long-term care facilities, home care agencies and pharmacies. The Canada Health Act does not prevent provinces from allowing private health care providers, whether individual or institutional, to deliver and be reimbursed for provincially insured health services so long as extra-billing or user charges are not involved.<sup>169</sup>

BC's six Health Authorities already contract millions of dollars in services with private providers for delivering clinical services, including MRI services, adult day care, home support services, long-term care facilities and cataract surgery.<sup>170</sup> Technological advances also mean that many diagnostic, therapeutic and surgical procedures that traditionally have been performed within a public hospital setting can now be safely and effectively completed in a private facility.<sup>171</sup>

A successful example of contracting out was the partnership between the previous North Shore Health Region and the Northmount Eye Surgical Centre. The Northmount Centre provided cataract procedures under direct contract to the Region. Surgical booking was done through the hospital, and the surgeons were required to have hospital privileges. Payment for cataract surgery at the Northmount Centre was on a per procedure basis, with a cap on total funding for a fixed number of procedures. Lions Gate Hospital, which contracted out 630 cataract surgeries a year to the private clinic, cut its wait list for cataract surgery by a third. The move also freed up 28 hours of OR time a week at Lions Gate, which meant an extra 60 surgeries could be performed.<sup>172</sup>

The BCMA supports the use of privately delivered, publicly funded health services if these services can be delivered as efficiently through the private sector while ensuring quality of patient care that is at least equal to that provided by the public sector. This sentiment is consistent with public opinion. In a June 2004 Environics Poll, two-thirds of Canadians said they support having health care services provided by the private sector as long as patients do not have to pay for them out of pocket. In Pollara's Health Care in Canada Survey (2003), 57% of Canadians also supported the idea of government contracting out the delivery of some publicly funded health services to private clinics.<sup>173</sup>

To ensure that P3s and contracting out are effective, targets for reducing wait lists should figure prominently in any contracts with private providers. Private contractors must also be required to report, on a standardized and comparable basis, the extent of their contracting, numbers and types of services being contracted, total amounts and rates and any provisions that allow for additional, uninsured services. The use of service-based funding, as discussed later (see the section on Funding), should help in determining the cost-effectiveness of P3s. Likewise, formal, independent evaluations of P3s should look at the total costs as well as their impact on patient care and waiting lists.

***Recommendation #9***

***Where public-private partnerships (P3s) and contracting out are used as strategies to reduce waits, formal, independent evaluations should look at total costs, their impact on patient care, wait times, and professional and public satisfaction.***

In Alberta, Regional Health Authorities annually contract for as much as \$750 million in services with private providers including for-profit and non-profit delivery of clinical and non-clinical services. The Alberta Medical Association, in a position statement on Health

Authorities contracting with private surgical facilities, recommends amending current legislation and regulations to ensure that:

- Health Authorities be held publicly accountable for contracting services.
- Health Authorities be required to report publicly – on a standardized and comparable basis – the extent of their contracting, numbers and types of services being contracted, total amounts and rates, and any provisions that allow for additional, uninsured services.
- Contracts should specify all “enhanced services” (i.e., uninsured “add-ons” associated with the provision of the insured service) that are permitted and specify that the timeliness of patient access will in no way be related to the purchase of those enhancements.
- Those responsible for awarding contracts must not have interests, direct or indirect, in the facilities receiving them.<sup>174</sup>

The BCMA believes that these recommendations should also be enshrined in BC, as P3s need to operate within a properly regulated framework with provincially determined quality controls.

### **Establishing Wait Time Benchmarks**

As previously discussed, in December 2005 Health Ministers across Canada unveiled ten key benchmarks aimed at cutting wait times for medical services. Ontario has gone even further by establishing wait time targets for the five key areas. We believe Ontario has taken the correct approach to include benchmarks for diagnostic imaging, as such technologies have become a central practice of modern medicine. Without timely access to diagnostic tools, the proposed benchmarks in cancer treatment, joint replacement and cardiac care may be irrelevant. The Wait Time Alliance (WTA) has raised additional concerns over the proposed First Ministers Benchmarks including the following:

- Benchmarks for cataract surgery should apply to all patients, not just those at high risk, and other sight restoration procedures (e.g., glaucoma) should be included.
- Other cardiac surgeries besides bypass procedures (e.g., angioplasty) should be included as part of the benchmark for cardiac care.
- The benchmark for radiation therapy should be decreased from 4 to 2 weeks.<sup>175</sup>

Although the BCMA applauds the establishment of benchmarks, it is important to note that the new standards are not binding on any of the provincial or territorial governments and do not have to be met for at least two years.

Identifying an agreed-upon reasonable amount of time for a patient to wait for a particular treatment or service is critical for targeting reduction efforts and resources.<sup>176</sup> According to a March 2004 Ipsos Reid/CMA poll, 88% of Canadians felt they have the right to know how long they can expect to wait for needed treatments.<sup>177</sup> As a major priority, the government, in collaboration with practising physicians, must continue to determine what are medically acceptable benchmarks for all surgical and diagnostic procedures, not just those five identified

key areas. Ideally, any benchmarks should be pan-Canadian and, thus, apply uniformly across Canada.

The development of these benchmarks should build on the previous work of the Western Canada Waiting List (WCWL) Project and the WTA.<sup>178</sup> Currently a number of countries, including the UK, New Zealand, Australia, Italy, Sweden, the Netherlands, Ireland and Finland, have established wait time benchmarks ranging from 3 to 12 months.<sup>179</sup>

Establishing reasonable wait time times will also require a consideration of external factors that influence waits. For example, a number of factors that can affect the adherence to medically acceptable wait time benchmarks include the following:

- Availability of health human resources
- Availability of equipment and technologies
- System coordination
- Assurance that limited medical resources are not inappropriately used
- Expectations of patients, providers and funders<sup>180</sup>

The WTA has published a number of principles for establishing medically acceptable wait time benchmarks, including that wait time benchmarks must be developed from the patient's perspective and with patient involvement. The BCMA believes that these principles, as outlined in Appendix B of this paper, are fundamentally sound and should be incorporated into the development and implementation of any new benchmarks.<sup>181</sup>

Determining new or revised acceptable wait times or benchmarks will also require fundamental improvements in obtaining data on how long people are actually waiting for surgery. This will require creating appropriate information systems to collect such data along with developing standardized or universally accepted definitions of wait times. In particular, Health Authorities must develop standard approaches and systems to measure wait times and the various components of waiting.

The BCMA agrees with the Health Council of Canada that 1) enrolment on a wait list should take place when the intervention is formally booked, and 2) the waiting interval should be defined as the time from initial referral to the specialist to completion of the procedure. In other words, the actual wait time should begin at the point when a patient and GP believe a referral to a specialist is necessary, not when the procedure is ultimately booked. Other approaches to priority-based surgical scheduling could be acceptable, provided that they reflect a similar intent with respect to medically acceptable wait times, and that they could be shown to treat patients and surgeons equitably, without undue administrative burden or unanticipated effects on surgical scheduling and resourcing.

Along with establishing designated wait time benchmarks, the BCMA believes that there should be a single wait time for completing all procedures as exists in other countries like Spain, Sweden and the UK. The BCMA believes that a six-month target for all diagnostic, therapeutic and surgical treatments is reasonable and should be adopted.

## Issues with Benchmarks

There are a number of issues that must be resolved prior to the implementation of benchmarks. Some of the key issues include:

- The ability of health care system to meet the benchmarks given limited capacity and resources.
- The legal obligations of government for not meeting timelines.
- The implications for physicians as clinical prioritization standards reduce discretion and require adherence to standards or guidelines.
- The focus on administrative targets as opposed to improving public/health outcomes.<sup>182</sup>

One of the main concerns with establishing benchmarks is that a possible conflict between medically acceptable waiting times and clinical prioritization may result. Specific guarantees of treatment within a predetermined time would imply that people with lesser conditions might be treated in an inappropriate order to meet the constraints of the guarantee.<sup>183</sup> This behavior conflicts with clinical priority and the guarantee may, in practice, act as a guarantee for low-priority patients. In 2001, the National Audit Office in the UK reported that 20% of specialists frequently treated patients in a different order to their clinical priority to avoid patients exceeding the 18-month wait list target.

One solution to the clinical prioritization issue has been advocated recently in several countries, including Denmark, the Netherlands and Italy, which have introduced conditional guarantees in terms of a percentage of patients. For example, Italy has set a target of having 50% of hip replacement patients receive surgery within 90 days, and 90% within 180 days.<sup>184</sup> Such targets have also been established in various provinces such as Saskatchewan which has set a target of having 95% of cancer-related surgeries carried out within 3 weeks. This formulation seems promising since it offers a possible solution to the clinical prioritization issue by introducing “discretion” in the system.<sup>185</sup>

Determining a single medical benchmark for diagnostic tests (e.g., MRI) may prove difficult and/or inaccurate. For example, because MRI is a diagnostic procedure, the task of assessing relative urgency is complicated by the need to estimate the likelihood that the MRI will provide critical diagnostic information, whereas most wait listed surgical procedures are applied to patients with established diagnoses.<sup>186</sup> Furthermore, any appropriate benchmark will depend on what the reason is for the diagnostic test. As a result, it makes more sense to establish specific diagnostic benchmarks for certain procedures (e.g., CT scan for lung cancer) as opposed to a single benchmark for all diagnostic procedures.

In summary, the effective implementation of benchmarks requires the following elements:

- The benchmarks apply across Canada.
- Extra resources be provided and capacity in the system be expanded to meet the standards set out in the benchmarks.

- Wait lists be standardized and reasonable wait times for various medical procedures be determined by competent medical bodies based on sound medical and scientific outcome evidence.
- There be adequate incentives to increase activity.
- Once an unreasonable wait exists, the patient's physician be empowered to seek and mandate the needed service in the public or private sector wherever it may be found.
- The benchmarks be reviewed on a regular basis and revised accordingly based on consensus from practising physicians.

We believe the idea of benchmarks is long overdue. The BCMA, therefore, recommends that wait time benchmarks for all major diagnostic, therapeutic and surgical services be introduced no later than December 31, 2007. Along with specific benchmarks, there should be a maximum six-month waiting time benchmark from GP referral to the provision of service.

**Recommendation #10**

***Wait time benchmarks for all major diagnostic, therapeutic and surgical services be introduced no later than December 31, 2007. Along with specific benchmarks, there should be a maximum 6-month waiting time benchmark from GP referral to the provision of service.***

As part of the establishment of benchmarks, the BCMA recommends that the provincial government also pay for travel costs for patients and their immediate families who must travel to other jurisdictions to receive procedures.

In its paper *Better Access, Better Care*, the CMA elaborates on the idea of a Health Access Fund, stating that Health Canada could administer the fund on behalf of the federal, provincial and territorial governments. To ensure that there are no perverse incentives for provincial health care plans to transfer the sickest and most complex and costly cases to other jurisdictions, the host jurisdiction could charge the other province the full case-mix costing, including both direct and indirect patient care costs, in addition to any travel costs borne by the patient.<sup>187</sup>

More recently, the WTA has recommended that the federal, provincial and territorial governments establish a 5-year \$2 billion Health Access Fund to enhance portability of care for patients and their families by reimbursing the cost of out-of-jurisdiction care when the services are not available provincially within the accepted wait time benchmark.<sup>188</sup>

The BCMA believes that a fund similar to those outlined by the CMA and the WTA be created to support patient care costs as part of the introduction of wait time benchmarks. In particular, the BCMA recommends that where a designated service cannot be made available to patients in the originally referred location and within the guaranteed period, patients should be entitled to obtain treatment elsewhere, at no cost to them. Treatment could be obtained at another public facility in or out of province, or in a privately owned facility, in or out of country.



**Recommendation #11**

***The provincial government pay for the treatment, travel and other appropriate costs for patients who must travel to other jurisdictions to receive services within wait time benchmarks.***

**Wait List Management Tools****Central Registries and Patient Prioritization Tools**

In Canada and BC, patient prioritization is not standardized or universal for most medical surgeries. Results of a national survey of hospitals, regional Health Authorities, Ministries of Health, and other agencies reveal that with few exceptions, no valid and reliable means are used to assess the priority of patients on waiting lists, thus making it impossible to manage regional lists to ensure patients with the highest urgency are served first.<sup>189</sup>

Such deficiencies highlight the need to develop single coordinated lists for elective surgeries. Regardless of location, patients with similar health status should wait similar lengths for surgeries. Wait lists for health care should be centralized and coordinated by regional or provincial authorities with the guidance of individual health care providers.

Under a centralized wait list management system, patients and doctors should be able to choose between a preferred specialist with a longer wait time or the next available provider. A good model for centralized waiting lists is the Cardiac Care Network (CCN) of Ontario.<sup>190</sup> In BC, central registries are currently being developed through the Provincial Surgical Services Project (PSSP). As part of the PSSP, all Health Authorities are developing specialty-specific prioritization tools based on tools developed by the WCWL Project. Between January and December 2005, all Health Authorities piloted and evaluated the validity of at least five of these tools, beginning with the hip and knee replacement tool, the cataract surgery tool and the general surgery tool. Hospitals in BC are expected to have all 14 validated tools in place (as appropriate) by June 2006.<sup>191</sup>

***Issues with Central Wait List Registries***

The effective use of an electronic clinical registry will improve system responsiveness and allow health system managers and providers to better manage patient waiting lists. A provincial registry will also allow real-time reporting of wait times by region, institution and provider, and will benefit both patients and referring clinicians, who will have the option of choosing providers with shorter wait times.<sup>192</sup> The table below summarizes some of the main arguments for and against central wait list registries.

Pros and Cons of Central Wait List Registries	
Pros	Cons
<ul style="list-style-type: none"> <li>▪ Proper centralized management of wait lists can eliminate unfairness as more urgent cases go first.</li> <li>▪ Ontario CCN has proved successful in reducing wait times</li> <li>▪ Registries can provide information needed for good planning and management.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Successful management of waiting lists requires additional money for administration.</li> <li>▪ It is not clear whether success of CCN can be repeated elsewhere and for other services (e.g., WCWL).</li> <li>▪ Relying only on standardized approaches may be too rigid.</li> </ul>

*(Commission on the Future of Health Care in Canada, Discussion Paper "Access to Healthcare in Canada", May 2002)*

As with the idea of establishing benchmarks, there are issues that need to be addressed prior to the implementation of central registries. One such issue is that the development and maintenance of central registries will require extra resources. Although central registries and priority scoring systems such as Ontario's CCN provide more rigorous measurement and reporting of wait times, they are costly to develop and maintain.<sup>193</sup> For example, the annual administration costs of the CCN is approximately \$1.75 million.<sup>194</sup>

Another major issue is ensuring that any patient information held in databases is adequately protected. Health information is one of the most sensitive forms of personal information. Without confidence that privacy will be protected, patients may refrain from disclosing critical information, be reluctant to provide their consent to use health information for research purposes and avoid health care encounters.<sup>195</sup>

The development of central registries must include meaningful input from practising physicians, patients, professional regulatory bodies and privacy agencies. The development of such registries should also be subject to a privacy impact assessment, specifying the need for proper security controls including log-in mechanisms with two-factor authentication and random audit trails. Patients should also be informed about the existence of the registry, why their information is gathered, how it is used and what safeguards are in place to ensure their information is secure.<sup>196</sup>

To ensure that central registries are accurate, they must be updated and audited regularly. Audits of centralized lists have found that 20% to 30% of patients should not be on the lists, either because they received the service elsewhere and no longer wanted or needed it.<sup>197</sup> Although regular audits will not necessarily shorten wait times, they will make it easier to predict how long the waits will be and to plan appropriately.<sup>198</sup>

**Recommendation #12**

***The BCMA support the continued development and implementation of central registries in BC, like the Provincial Surgical Services Project. The development of central registries must include meaningful input from practising physicians, patients, professional regulatory bodies and privacy agencies.***

**Recommendation #13**

***The provincial government's central wait list registry be updated and audited on a regular basis to ensure the accuracy and integrity of data.***

**Recommendation #14**

***The privacy of patient information in central registries be protected through audit trails and authentication mechanisms.***

*Issues with Patient Prioritization*

The principal functions of priority criteria are to guide decisions about the relative urgency and order of assessment or treatment among patients on waiting lists. This allows the development of case-mix descriptions of patients to assess and compare wait lists across regions and over time.<sup>199</sup> However, while classifying patients by urgency may improve efficiency and fairness, it will not shorten wait times unless extra funding and other resources are used to manage existing backlogs and coordinate care as new patients arrive.<sup>200</sup> For this reason, the BCMA advocates that extra funding be used to clear existing backlogs (see Recommendation 28). Ideally, the extra capacity would lessen the need for prioritization tools.

In key areas such as cardiac care and radiation therapy, reaching a consensus among physicians on severity thresholds for prioritization is straightforward because the consequences of not providing timely care can be catastrophic. For example, with respect to cardiac surgery, objective, quantifiable data (e.g., percent of vessel stenosis) can be used to classify patients.<sup>201</sup> In contrast, determining clinical priority for other procedures such as diagnostic tests may prove more difficult.

Despite its difficulties, patient prioritization is critical for the successful management of wait lists. It is also widely supported by the public. In a 2003 CMA/Ispos Reid poll, 95% of Canadians responded that queue placements should be awarded on the basis of seriousness, while only 5% believed it should be first-come, first-served.<sup>202</sup>

To date, the WCWL Project has made considerable progress in developing tools for prioritizing patients.<sup>203</sup> However, as stated in section IV of this report, the WCWL project was closed on April 1, 2006 due to a lack of funding. Despite the progress made by the

WCLW, the project was closed on April 1, 2006 due to a lack of funding. This is lamentable, as the WCWL's pioneering process for developing maximum acceptable wait times set a precedent for collaboration and led to one of the few mechanisms for improving accountability. We believe that clinical prioritization initiatives like the WCWL project should be pursued further if central wait list registries are to be successful. For any priority systems to be successful there are five critical factors that must be followed:

1. They must be clinically led by practising physicians.
2. There must be provincial coordination and support for clinical prioritization systems, particularly by physicians and patients.
3. They must be clinically validated by practising physicians.
4. They must not interfere with individual patient/physician decision making whereby other factors may also influence the optimal timing of surgery.
5. Physicians must be compensated appropriately for the completion and submission of patient prioritization tools.

### **Evidence-based Clinical Guidelines and Best Practices**

To ensure patients are placed on wait lists when appropriate, practising physicians must have access to up-to-date evidence-based clinical guidelines. Cancer Care Ontario (CCO), for example, is leading an initiative to develop specific guidelines for the use of diagnostic imaging to identify stages of cancer, monitor response to therapy and follow up patients for recurrence.<sup>204</sup> The Canadian Association of Radiologists (CAR) is also developing evidence-based guidelines for all diagnostic imaging procedures, including MRI and CT scans.

The BCMA believes that the creation of clinical guidelines should be led by practising physicians and their development and implementation be actively supported and funded by governments. Guidelines should also be developed to ensure patients waiting for treatment are given advice on how to cope better and minimize the deterioration of their condition.<sup>205</sup>

In BC, guidelines and protocols are developed under the direction of the Guidelines and Protocols Advisory Committee (GPAC), which is sponsored by the BCMA and the Ministry of Health. Established under section 5(1) of the Medicare Protection Act, the GPAC serves as an Advisory Committee to the Medical Services Commission (MSC). To date, the GPAC has established a number of guidelines on various areas such as chronic disease (i.e., diabetes care) and diagnostics (i.e., x-rays and mammography). The work of the GPAC should continue with an added priority of reducing and improving the management of wait times through the development and implementation of clinical guidelines.

**Recommendation #15**

***The BC Guidelines and Protocols Advisory Committee (GPAC) continue to develop evidence-based guidelines for appropriate clinical indications for selected services. The development and implementation of these guidelines should continue to be supported and funded by government.***

Along with the development of clinical guidelines, the BCMA advocates that a similar program to the National Demonstration Hospital Program (NDHP) in Australia be explored for adoption in BC. As stated earlier, Australia's NDHP was established in 1995 to reduce clinically inappropriate wait times for elective surgery by identifying and disseminating strategies to overcome barriers to improved management of the whole elective surgery process. An 18-month evaluation study following the project suggested that 61% of the hospitals had overall efficiency gains, while OR use increased by 5.1% and the number of procedures increased by 5.5%. Cancellation of surgery on the planned day of admission also decreased by 59%, while the rate of unplanned, unbooked readmissions fell by 26%.<sup>206</sup>

Best practice strategies should also identify methods for hospitals and surgical facilities looking to improve patient flows so that, once treated for elective surgery, patients are released in an efficient and timely manner. The New Zealand government, in a report on wait lists, mentions a number of strategies to improve patient flows including the use of day surgery for an increasing range and number of procedures, more flexible rosters for OR staff to maximize use of surgeon and theatre availability, and establishing a list of short-notice patients to fill gaps created by cancellations.<sup>207</sup>

In summary, the BCMA believes that the BC government should develop a program to reward best practices in hospitals, surgical facilities and post-hospital care in reducing wait times and improving patient outcomes. Such a program would help identify solutions to reduce wait times such as minimizing inefficiencies, adopting technology, reducing bottlenecks in patient flow, developing standardized tools and procedures, etc.

**Recommendation #16**

***The BC government, with practising physician input, develop a program to reward best practices in hospitals, surgical facilities and post-hospital care for reducing wait times and improving patient outcomes.***

**Accuracy of Wait Lists**

As noted earlier, institutional and administrative barriers are major factors that can result in increased wait lists. For example, many hospitals are subject to lengthy approval processes for diagnostic equipment that could be used to shorten wait times. Too often wait lists only reflect the wait between when the procedure is booked and when it is

performed. In many cases there is often a significant delay between the diagnosis and when the procedure is actually booked. Analyzing the wait between when the procedure is booked and when the surgery occurs does not account for any waits for diagnostics that patients may face. As noted in a report by the Health Council of Canada, patients on wait lists are also often re-booked as many systems do not track waits longer than a year.

In summary, ensuring the accuracy and integrity of wait list information is critical for better managing wait lists. Without accurate information on how long patients are actually waiting, it will be difficult to implement many of the wait list management strategies presented in this paper such as establishing benchmarks, developing clinical prioritization tools and central registries, improving accountability and implementing best practices. Determining accurate wait times will also rely heavily on enhancing Information Technology, as discussed below.

### **Enhancing Information Technology**

The state of wait list information and management systems in Canada is woefully inadequate, particularly for elective procedures.<sup>208</sup> One reason for this state of affairs is because of insufficient funding for information technology (IT) in Canada's health care sector. Currently, IT spending consumes on average about 2.5% of health operating budgets. Health care organizations in the US, in contrast, spend approximately 5% of their budgets on IT systems, a figure that is projected to increase to 6.9% by 2006.<sup>209</sup> In Sweden, hospitals invest on average 4% of their budget on Information and Communication Technologies (ICTs), compared with Canadian hospitals that spend between 1.8% and 2.5% of their budgets on ICTs.<sup>210</sup> A recent survey of Canadian hospital and health-region Chief Information Officers also found that at least 4% of the operating budget is required to successfully implement their IT plans.<sup>211</sup>

For the development of central registries and the successful management of wait lists, increased funding for IT will be critical. The BCMA has previously recommended that the BC government allocate \$210 million over three years to advance the implementation of a health IT infrastructure for the province. The BC government, however, has taken a positive step with the creation of the new Physician Information Technology Office (PITO) as outlined in the 2006 Letter of Agreement between government and the BCMA. Over the next six years (2006/07-2011/12), the PITO will be responsible for allocating \$107.8M in funding to facilitate the implementation of IT systems, including electronic medical records, in physician offices.

In May of 2006 the provincial government also announced that \$150 million in funding will be dedicated for various eHealth initiatives between 2005/06 and 2008/09. Of this, Canada Health Infoway has conditionally agreed to provide \$120 million of the costs, while the Ministry of Health will allocate \$30 million. This funding will go towards realizing BC's eHealth strategy, which comprises 22 projects grouped into nine areas – primary care, hospital care, home and community care, public health, laboratories, pharmacies, diagnostic imaging, telehealth, and foundational projects.<sup>212</sup> Additional funding, however,

will be required not only to implement IT in physician offices but also to ensure that other areas of the health care system, including hospitals and long-term care facilities, have information systems which are integrated with the entire health care sector.

One specific area of IT which can potentially reduce wait times, particularly to see a specialist, is telemedicine. In the Interior Health Authority, for example, thoracic surgeons practising in a specialist centre in Kelowna can consult with patients and health care providers across rural and remote parts of northern BC. Along with increasing greater access to specialists, telemedicine minimizes the need for patients to travel. Telehealth video conferencing is operational in over 66 communities in BC and is in use in 125 dedicated sites.<sup>213</sup>

Like many information systems, however, telemedicine is still largely in its infancy stage. There are a number of areas where the technology will also need to be improved, including scanning technology, navigation and image visualization capabilities. Another significant barrier to the practice of telemedicine is the lack of quantitative data on the reliability and cost effectiveness of the technology.<sup>214</sup> Finally, unresolved reimbursement and funding issues also constitute major barriers to the widespread use of telemedicine.<sup>215</sup>

The BCMA believes that increased funding must be directed to IT solutions, particularly in individual practices, that can reduce and better manage wait lists. This includes, as outlined earlier, the development of computerized central wait list registries. It is also critical that practising physicians, representative of and accountable to their professional colleagues, be integrally involved in the development of health IT solutions.<sup>216</sup> Such systems should also be at no cost to physicians to implement.

#### **Recommendation #17**

***The BC government and Health Authorities, in collaboration with practising physicians, work towards the province-wide integration of health data, including central wait list registries to reduce and better manage wait lists. It is recognized that this will require additional IT funding from government and health authorities.***

#### **Incentives for Hospitals and Physicians to Reduce Wait Lists**

Incentives for health care facilities and physicians have proven an effective strategy to reduce wait times. In Spain, funding allocations to hospitals and compensation to physicians have been effective in reducing its wait times. In fact, by 2000, maximum wait times were down to six months and the overall mean wait time was reduced to 55 days.<sup>217</sup> Bonuses for specialists who have achieved wait times reductions have also contributed to a steady reduction in waiting times. Other nations that have introduced similar incentives include the UK, Ireland and Australia.<sup>218</sup>

*Issues with Incentives*

The introduction of financial and non-financial incentives to reduce wait times will likely induce major changes in the behavior of hospitals and its surgeons. On the one hand, a hospital and its surgeons may increase the level of supply of elective treatments or surgeons may reduce the demand for elective treatments by raising their thresholds for adding patients to the waiting list. The shortening of wait lists does not necessarily signal an equal increase in productivity if there is an incentive to admit fewer patients to the lists.<sup>219</sup>

To ensure there are no perverse incentives, the BCMA advocates that any targeted incentives to reduce wait lists be conditional on a decrease in wait times as well as an increase in surgical activity. Likewise, the reduction of various wait lists should not result in increased waits in other areas simply by shifting available resources. Without such conditions it is possible that hospitals could reduce wait times simply by placing fewer people on the wait lists. Overall, we believe this would not be an acceptable approach to reducing wait lists.

**Recommendation #18**

***The BC government provide incentives for hospitals and physicians to reduce wait times in the province, conditional on both a decrease in wait times and an increase in services delivered.***

**Improving the Interface between Primary and Specialty Care**

One aspect often overlooked in managing or reducing wait lists is the role of the GP. Having a well-functioning primary care system is essential for the better management of wait times, as GPs play a crucial role in monitoring and caring for patients on wait lists. Primary care is also where many preventive activities occur (e.g., health promotion) that reduce the future need for surgeries. Currently, the existing primary care system is being undermined as fewer GPs are entering full-spectrum practice.

Reversing the downward decline of full-spectrum family practice, as well as addressing the shortage of family doctors, will be critical for better managing and reducing wait lists in BC. Therefore, the BCMA advocates that as part of any strategy to renew primary care, the role of the family physician in reducing and managing wait lists be explored further.<sup>220</sup> Ensuring that wait lists are properly managed will also require an appropriate level of interface between primary and specialty care. Not only should GPs have access to up-to-date information about the estimated wait time for inpatient and outpatient treatment, they will require greater flexibility in accessing hospital services. A solution advocated by the New Zealand government is the establishment of joint primary/specialist working groups to develop appropriate and quicker GP-patient access



to specialist assistance. Examples of other such initiatives that could be explored further include:

- GPs working within hospitals to improve referral quality by providing feedback and ensuring referrals are directed to the most appropriate access/assessment option.
- Developing GP skills through education and a certification process to enable a better level of assessment and management to be undertaken in primary care.
- Expanding the role for certified GPs in follow-up assessment activities.
- Allowing direct GP access to diagnostic services such as ultrasound, MRI and CT scans.<sup>221</sup>

Other activities to support the interface of primary and specialist care that should be considered is expanding on the work done by the WCWL Project, which has developed point-count systems to prioritize referrals from primary care physicians to specialists. The objective is to create user-friendly, clinically coherent scoring systems that specialists can use to judge the urgency of referrals from primary care physicians, based on modifications of the original WCWL Priority Criteria Scores.<sup>222</sup>

Improving the interface and coordination of care between GPs and specialists is critical to reducing and better managing lengthy wait times. A 2004 report from the UK notes that systems that improve the coordination between primary and specialist care are also essential for the management of chronic diseases, a leading cause of increased wait times.<sup>223</sup> As a result, the BCMA recommends that strategies be developed jointly with the BC government to improve the interface between primary and specialist care in an attempt to reduce and better manage wait lists. These tasks could potentially be undertaken by the new trilateral Shared Care and Scope of Practice Committee (SCSPC) as outlined in the new Letter of Agreement (LOA) between the BC government and the BCMA. The SCSPC, which must issue a report no later than March 31, 2009, is to develop recommendations to enable shared care and appropriate scopes of practice among GPs, specialists and other health care professionals.

#### **Recommendation #19**

***Strategies be developed jointly by the BCMA and the BC government to improve the interface between primary and specialist care in an attempt to reduce and better manage wait lists.***

#### **Improving Accountability**

Accountability within health care reflects the degree to which providers, patients and payors take shared responsibility for decision making and care provision. The BCMA supports the need for accountability in all aspects of health care funding and delivery.

### **Physician Accountability**

BC's practising physicians are responsible both legally and ethically for the care they provide and they are held to a high standard of scrutiny regarding the delivery of medical services. The College of Physicians and Surgeons of BC, in conjunction with the BCMA, administers comprehensive programs to monitor and enhance physician performance. The College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada oversee mandatory programs of continuing medical education and professional development as part of their maintenance of certification. Additionally, physicians are subject to peer review, audit and inspection.

Numerous regulatory steps already exist to ensure provider accountability, including peer review and clinical practice guidelines and payment protocols. Physicians in BC are also subject to audit and inspection by the College of Physicians and Surgeons, as well as by government. The BC Medical Services Plan routinely audits claims by physicians to ensure that they are billing correctly and appropriately. Continued effort is needed, however, to ensure that physician services reflect best practices and lead to better outcomes, particularly with respect to reducing and better managing wait lists.

### **Patient Accountability**

A valid criticism of BC's health system is the lack of patient accountability. In a 2001 CMA public opinion survey, 61% of respondents felt that many Canadians misuse the health care system. A December 1999, Mark Trend BC public opinion poll found that 48% identified public over use of the health care system as a major problem.

There are no incentives for patients to take personal responsibility for their use of medical services. Government has been complicit in this behaviour by avoiding any explicit disincentives and/or limits on public entitlement to "free" medical services. Without direct accountability, human nature is such that many individuals maximize their use of medical services. Most countries, for example, require some form of patient co-payment for their use of medical services. Of 27 OECD countries surveyed, Canada is one of only six that do not have cost sharing for the major services of hospital care, general practitioner care, or specialist care.<sup>224</sup> It is important to ensure, however, that co-payments do not represent a financial barrier to seeking care. Many countries currently have exemptions for lower income patients. In New Zealand, for example, low income residents are eligible for a Community Services Card (CSC), which provides subsidies for GP visits as well as prescription drugs.

### **Government Accountability**

Government accountability for health care decisions is lacking. This issue is starting to be addressed as part of the First Ministers' 10-Year Health Plan, which provides \$5.5 billion over ten years for a Wait Times Reduction Fund.<sup>225</sup> As part of the agreement, First Ministers are to achieve meaningful reductions in wait times in priority areas such as

cancer, heart, diagnostic imaging, joint replacements and sight restoration by March 31, 2007.<sup>226</sup>

Although it is encouraging that these provisions are in the 10-Year Health Plan, there are no apparent ramifications if the provincial or federal governments fail to meet these targets. The BCMA believes that the development of and adherence to evidence-based benchmarks for all surgical and diagnostic procedures is an important step to increasing accountability and addressing the wait list problem. One way to do this is for the federal government to withhold funding to provinces that do not establish performance targets. According to a 2005 Ipsos Reid poll commissioned by the CMA, 62% of Canadians believed that the federal government should withhold all or some of the increased funding to the provinces and territories until its commitment to establish benchmarks are met.<sup>227</sup>

To improve accountability, it is also critical that the results of the government's wait list management efforts be readily available to the public and health care providers. The wait times reported should be accurate indicators of how long patients are actually waiting for care. The BCMA applauds the provincial government's efforts in maintaining and tracking a surgical web site outlining the median waits in BC.<sup>228</sup> As noted earlier, in BC wait times for hospital-based surgeries and services in approximately 20 different categories are tracked, monitored and updated on a regular basis in a Surgical Wait List Registry.<sup>229</sup> The BCMA believes, however, that improvements can be made to both the registry and the web site. For example, the BCMA advocates that multiple measures aside from median waits be used in order for the public and providers to have a better understanding of actual wait times. The BCMA also advocates that the web site be overseen by the proposed BC Wait Times Commission (BCWTC) outlined below (see the section on the BC Wait Times Commission).

A report from the Health Council of Canada (HCC) notes there are various inaccuracies when reporting average or median waiting times, as the former provides a more favourable estimate while the latter is completely insensitive to the extremes of the wait time distribution. Other problems with wait list data occur when the date that a procedure is booked differs from when it is originally requested from a specialist. As mentioned earlier, re-booking for patients on wait lists, for example, is quite common as many systems do not track waits longer than a year.

To overcome these biases, the HCC recommends that jurisdictions use percentiles to report on the distribution of wait times instead of quoting averages or medians. They also recommend using the date of the original booking request as the start date (in addition to the referral date), no matter how many times the case is rescheduled, and tracking the number of, and reasons for, cancellations or re-bookings as part of the minimum dataset.<sup>230</sup> The BCMA believes that these approaches advocated by the HCC (see appendix D) are fundamentally sound and should serve as the basis for developing a framework and strategy to deal with wait lists. The BCMA also believes, as stated earlier, that the total wait time should be measured from GP referral to the provision of the service.

**Recommendation #20**

***Governments, Health Authorities and physicians develop standardized approaches and definitions, supported by appropriate information systems, to measure how long patients are actually waiting for surgical and diagnostic procedures.***

**Recommendation #21**

***The BC government and Health Authorities report accurate wait list times in a clear and concise manner to patients and health care providers on a monthly basis. Total wait times should be measured from time of GP referral to the provision of the service.***

**Minimum Health Authority Targets through Performance Agreements**

Ontario has been the most active jurisdiction in Canada in improving accountability for reducing wait lists. Ontario's Wait List Strategy, as discussed earlier, highlights the need to make hospitals and health authorities more accountable. In particular, Ontario's strategy states that the government will monitor the performance of hospitals against established targets and hold organizations accountable.<sup>231</sup> As part of the purchase service agreements signed between the Ontario Ministry and hospitals, the strategy specifies the conditions that hospitals must meet to receive funding for additional procedures.

BC's six Health Authorities are required to sign performance agreements with the provincial government to hold them accountable for the delivery of patient care, health outcomes and how health dollars are spent. These performance agreements define expectations, performance deliverables and service requirements in the areas of emergency care, surgical services, home and community care, and mental health services for three fiscal years. The agreements were first signed in 2002 and are to be updated and renewed annually for each three-year period.<sup>232</sup>

Although we applaud the provincial government for developing such performance agreements with the Health Authorities, we believe they can be improved. A 2003 report from the Office of the Auditor General of BC raised a number of concerns with these agreements, including that the performance measurements are too vague and do not contain a clear expression of key expectations.<sup>233</sup>

The BCMA believes that performance agreements with the Health Authorities should include specific wait list reduction targets. More specifically, the performance agreements between the BC government and Health Authorities should include wait time benchmarks with incentives to meet performance targets as well as disincentives for failing to meet targets. The performance agreements should also outline that the Health Authorities

meet the wait time targets by increasing the number of surgical procedures rather than putting fewer patients on the waiting lists.

**Recommendation #22**

***The Performance Agreements between the BC government and Health Authorities include specific wait time benchmarks with incentives to meet performance targets as well as disincentives for failing to meet targets.***

**BC Wait Times Commission**

The successful implementation of the recommendations presented here will require the active participation of all major health care stakeholders including physicians, health authorities, government and the private sector.

The BCMA believes that wait list initiatives, such as the Provincial Surgical Services Project (PSSP) outlined earlier, be coordinated and communicated to practising physicians on a province-wide basis. Such coordination requires meaningful input from providers at all levels. With respect to managing health care waiting lists, practising physicians, representative of and accountable to their professional colleagues, must be involved in the development of:

- Medically acceptable wait times for therapeutic, surgical and diagnostic procedures
- Tools designed to prioritize patients for surgery according to medical need
- IT systems including development of centralized wait list data registries
- Provincial and health authority initiatives to reduce wait times, including strategies to increase or reallocate resources (e.g., OR time, diagnostic equipment)
- Physician supply and health human resource plans
- Evidence-based guidelines for appropriate clinical indications for selected surgeries
- Monitoring and reporting of wait lists

Once benchmarks are implemented, mechanisms will also need to be put in place to report on evidence demonstrating how any activities have improved wait lists and whether established targets and standards are being met. To accomplish this, the BCMA recommends the establishment of a BC Wait Times Commission (BCWTC), comprising representation from the BCMA, BCNU, government and Health Authority representatives to oversee and monitor government compliance with respect to the wait time benchmarks.

In particular, this entity would ensure that patients are receiving care within the established benchmarks. If patients do not receive timely access to care within the benchmarks, then alternative arrangements would be made such as transferring patients to another jurisdiction to receive care. Such a body would also report annually on

performance and compliance with meeting the benchmarks, as well as make recommendations on how to improve patient access to timely care.

The BCWTC would make specific recommendations to the provincial government and the Health Authorities on where to allocate targeted resources. For example, the BCWTC could recommend that the provincial government allocate a specific amount of money to the Interior Health Authority to reduce long waits for hip and knee replacements at Kelowna General Hospital. In exchange, the Interior Health Authority would have to meet specific wait reduction targets. The BCWTC, which would report directly to the Minister of Health, would monitor the progress made in meeting these targets, while the Health Authorities would agree to specific deliverables in order to receive additional targeted funding.

***Recommendation #23***

***A joint BC Wait Times Commission (BCWTC), comprising representation from the BCMA, BCNU, Ministry of Health and Health Authorities, be established to make recommendations regarding targeted wait time funding.***

***Recommendation #24***

***The BCWTC be responsible for monitoring the progress of all wait list initiatives in the province to ensure that wait times are consistent with medically reasonable levels.***

***Recommendation #25***

***The BCWTC report annually on the performance at meeting the medically reasonable benchmarks, as well as make recommendations on how to improve patient access to timely care.***

## **Funding**

Many of the recommendations presented in this paper to reduce wait lists will require additional government funding. The \$5.5 billion from the federal government to reduce wait lists as part of the 2004 Health Accord is a good start, but more permanent funding will likely be needed. It is important to note that more public funding to reduce wait lists is only part of the answer. Instead of decreasing waits, increased funding may also see an initial increase in actual wait times as more patients are placed on wait lists. For example, extra capacity will likely generate additional demand, since the existing wait times have served as a deterrent for some seeking elective surgery.<sup>234</sup>

Overall, research has shown that additional funding, if properly targeted, is effective in reducing wait lists. For example, a recent study found that with extra government funding for coronary artery bypass grafting (CABG), surgeons in BC were able to increase the number of operations by 12% in 1999/00 (4,174) compared with 1995/96 (3,696).<sup>235</sup> CABG wait times shortened after extra funding was provided on an annual basis to tertiary care hospitals.<sup>236</sup> In part due to such funding, BC now has among the lowest waits for cardiac care in Canada.<sup>237</sup> According to BC's Health Authorities, targeted provincial funding of \$16.7 million that was announced in September 2004 also helped them perform 39% more hip and knee surgeries in 2004/05 compared with the previous year.<sup>238</sup> Initial data from Alberta also show that \$20 million in targeted funding as part of its Hip and Knee Replacement Project has proven very effective in reducing waits.<sup>239</sup>

The BCMA believes that as a priority, funding should be given to those procedures and/or regions where access issues are most significant. In particular, the BC government should provide funding to ensure that the citizens of BC have equitable access to necessary medical services regardless of geographical location. It is important, however, that resources targeted for other surgeries should not be diverted to achieve reductions in the five priority areas identified earlier. As a short-term goal, targeted funding should be provided by the BC government to bring the province into compliance with established wait time benchmarks. As a long-term goal, timely access should be available for all health care interventions.

As part of the 2004 10-Year Health Plan, the BC government will receive a total of \$5.4 billion new federal funding over the next ten years, including \$715 million targeted specifically to reduce wait times.<sup>240</sup> BC's share of the Wait Times Reduction Fund will total approximately \$81 million in 2004/05 and 2005/06, \$156 million in 2006/07 and 2007/08, \$78 million in 2008/09 and \$32.5 million in 2009/10. The BCMA recommends that a significant portion of the new funding allocated until 2009/10 be used to increase the capacity of the acute care sector so that benchmarks may be realized.

As outlined earlier, the BC government announced in February 2006 that it would be allocating approximately \$60 million of its new federal funding toward reducing wait times for hip and knee replacements. Overall this new funding accounts for less than 10% of the total federal wait time funding to be allocated over the next ten years (i.e., \$715 million).

In contrast to developing a comprehensive long-term strategy with sustainable funding to reduce wait lists, the BC government seems more inclined to adopt an ad-hoc approach to reducing wait lists, with limited additional funding. The BCMA believes this approach is counterproductive and in the long-term may not result in significant reductions in wait times. Instead, the BCMA advocates that in accordance with the 2004 federal-provincial Ten Year Health Plan, that the BC Wait Times Commission (BCWTC) should, as one of its first tasks, develop a ten-year funding strategy to reduce wait lists in BC. More specifically, the 10-year strategic framework, which would outline detailed funding commitments, would explore plans for the following:

- Additional acute and long-term care beds.
- Increasing operating room capacity.
- Increasing access to diagnostic equipment.
- Reducing pressures on Emergency Departments.
- Increasing the supply of physicians and other health care professionals.
- Establishing specialty clinics province-wide.
- Contracting out services to private health care facilities.
- Establishing benchmarks and ensuring they are met by providing financial assistance to patients to travel and receive treatment in other jurisdictions if necessary.
- Developing central patient registries and prioritization tools.
- Ensuring best practices for reducing wait times, including incentives for hospitals and physicians to reduce wait lists.
- Enhancing information technology.
- Ensuring government, providers and patients are accountable for results.

**Recommendation #26**

***The BC government provide the necessary funding to ensure that the citizens of BC have equitable access to necessary medical services regardless of geographical location.***

**Recommendation #27**

***Targeted funding be provided to bring BC into compliance with wait time benchmarks.***

**Recommendation #28**

***A significant portion of the 2004 Federal-Provincial Ten Year Health Plan funding be used to clear existing backlogs and increase the capacity of the acute care sector.***

**Service/Activity-based Funding for Hospitals**

Hospitals in Canada typically receive an annual operational global budget from the provincial government to fund the delivery of care. These budget allotments are based on past allocations and annual adjustments to reflect changes in costs.<sup>241</sup> In BC, the provincial government allocates funding to Health Authorities for acute care, home and community care using a population-needs-based formula (PBNF) that considers factors such as demographics, patient flow, complexity of cases and remoteness.<sup>242</sup>

Although the BCMA has expressed concerns with the current PBNF model in the past we believe a regional funding model for hospital and community programs can be a useful tool, subject to its ability to effectively track and accommodate interregional patient



flow.<sup>243</sup> A portion of the funding from the PBNF model, however, should be allocated to hospitals based on an activity or service-based funding approach.

A more effective means of funding hospitals is through service-based funding or a diagnostic related group (DRG) payment system. Under this model, the government pays a fee for each individual cared for, based on the expected costs of treating the diagnosis of the patient at the time of admission. Service-based funding creates incentives for hospitals to treat more patients and, thus, reduce waiting lists.<sup>244</sup>

Experience from a number of OECD countries shows that using service or activity-based funding for health care not only increases surgical activity but is a key factor in reducing wait times. A 2003 OECD report, for example, noted that countries are less likely to report problems with wait times if they rely mainly on activity-based funding for hospitals instead of fixed budgets.<sup>245</sup> More specifically, none of the four countries that had mainly activity-based funding in 2000 (i.e., Austria, Japan, US and France) reported major waiting problems. As a result of its effectiveness in reducing wait lists, other countries such as Australia, Sweden, the UK and Germany are moving toward service-based funding. In April 2003, the UK's National Health Service began the phased introduction of activity-based funding for hospitals.<sup>246</sup>

The Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby (2002) also recommended service-based funding where hospitals would be paid an agreed-upon fee for each service they deliver after that service has been performed. A later report by authors Kirby and Keon stated that service-based funding will result in the following benefits:

- Encourage hospitals to improve operating efficiencies as they can keep or reinvest any money saved.
- Create competition among hospitals and smaller, more highly specialized clinics.
- Help develop highly specialized health care teams, achieving better outcomes for patients and making optimal use of costly equipment.
- Stimulate the development of centres of excellence for complex surgical procedures
- Improve quality of care as evidence shows a relationship between volume and patient outcomes.
- Encourage hospitals to improve patient service and drive out inefficiencies.<sup>247</sup>

#### *Issues with Service Based Funding*

Service-based funding, however, is not without its limitations. Although service-based funding may work well in urban community hospitals, teaching hospitals and rural or remote hospitals may need be treated differently as it is not possible to create a market for many of the services they provide. Extra or alternative funding arrangements, therefore, may have to be negotiated with rural or hospitals that do not have significant patient volumes but where it is deemed appropriate that such facilities should continue to provide certain services. As a result, the BCMA recommends that the BC government

and Health Authorities increase the percentage of service-based funding to Health Authorities, as an incentive to reduce wait lists.

***Recommendation #29***

***The BC government increase the percentage of service-based funding to Health Authorities, as an incentive to reduce wait lists.***

## Conclusion

Immediate action is needed so that British Columbians see real changes in wait times and the way wait lists are managed. This change will come about only if the government and stakeholders work together to develop a comprehensive strategy both to address the immediate crisis and to plan for the future. One step is to increase funding to the system. If allocated effectively, additional funding can reduce wait lists. But funding policy must be sustainable and part of a comprehensive strategy. This is why the BCMA advocates a ten-year strategy, developed by a newly-created BC Wait Times Commission, outlining detailed funding commitments. As well, any new funds that become available in the future should be clearly targeted towards effective strategies to manage and reduce wait times. Funding must be accompanied by accountability on the part of physicians, patients and government. Key to accountability is developing wait time benchmarks and the accurate reporting of how long patients are actually waiting.

Funding and a commitment by government, Health Authorities and physicians is needed to develop and implement wait list management tools such as patient prioritization mechanisms, volume incentives for hospitals and improved information technology. Today in BC, it is impossible to manage wait lists because there is no standard means of prioritizing patients. The BCMA fully supports initiatives such as the Western Canada Waiting List Project to establish effective and accountable tools for prioritizing patients. Further, the use of information technology must be enhanced to support the development of central wait list registries and improve current wait list management tools.

Acute and long-term care beds are in short supply in BC, operating rooms are underused, diagnostic equipment is lacking, emergency department waits are too long and physicians and other health professionals are too few. All these issues can be addressed with government commitment to a long-term strategy and focused funding.

The time has come for greater cooperation to ensure that today's problems do not continue tomorrow. Patients are waiting too long, and this report provides a prescription for reducing and better managing waits in BC. There is no more time to wait.

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## APPENDIX A

### List of Recommendations

#### Building Capacity

##### **Recommendation #1**

*The BC government and Health Authorities commit to maintaining a routine acute care bed capacity level not exceeding 85% in hospitals.*

##### **Recommendation #2**

*The BC government fulfill its commitment to increase the number of long-term care beds by 5,000 by the year 2010.*

##### **Recommendation #3**

*The BC government and Health Authorities increase operating room capacity by at least 25% within the next 2 years and implement a strategy to see a further 25% expansion realized by 2009/10.*

##### **Recommendation #4**

*The provincial government, in conjunction with practising physicians, form a task force to develop strategies for increasing the availability and appropriate use of diagnostic equipment. The task force should have equal representation from the BC government, Health Authorities and the BCMA and report no later than March 31, 2007.*

##### **Recommendation #5**

*As an immediate priority, the BC government, BCMA and Health Authorities support a multidisciplinary approach, with a neutral chair, aimed at reducing Emergency Department (ED) waits and ensuring new funding is allocated appropriately. Long-term strategies to reduce ED waits province-wide should also be explored jointly by the BC government, BCMA and Health Authorities.*

##### **Recommendation #6**

*The BC government and the Health Authorities with the cooperation of the BCMA, reconstitute the dormant Physician Resource Planning Committee to develop a five year provincial physician supply plan no later than March 31, 2007.*

##### **Recommendation #7**

*The BC government, in conjunction with the BCMA, work toward the introduction of physician assistants within the health care system.*

**Recommendation #8**

*The BC government facilitate the creation and comprehensive clinical evaluation of Specialty Clinics to increase acute care capacity.*

**Recommendation #9**

*Where public-private partnerships (P3s) and contracting out are used as strategies to reduce waits, formal, independent evaluations should look at total costs, their impact on patient care, wait times and professional and public satisfaction.*

**Establishing Wait Time Benchmarks****Recommendation #10**

*Wait time benchmarks for all major diagnostic, therapeutic and surgical services be introduced no later than December 31, 2007. Along with specific benchmarks, there should be a maximum 6-month waiting time benchmark from GP referral to the provision of service.*

**Recommendation #11**

*The provincial government pay for the treatment, travel and other appropriate costs for patients who must travel to other jurisdictions to receive services within wait time benchmarks.*

**Wait List Management Tools****Recommendation #12**

*The BCMA support the continued development and implementation of central registries in BC, like the Provincial Surgical Services Project. The development of central registries must include meaningful input from practising physicians, patients, professional regulatory bodies and privacy agencies.*

**Recommendation #13**

*The provincial government's central wait list registry be updated and audited on a regular basis to ensure the accuracy and integrity of data.*

**Recommendation #14**

*The privacy of patient information in central registries be protected through audit trails and authentication mechanisms.*

**Recommendation #15**

*The BC Guidelines and Protocols Advisory Committee (GPAC) continue to develop evidence-based guidelines for appropriate clinical indications for selected services. The development and implementation of these guidelines should continue to be supported and funded by government.*

**Recommendation #16**

*The BC government, with practising physician input, develop a program to reward best practices in hospitals, surgical facilities and post-hospital care for reducing wait times and improving patient outcomes.*

**Recommendation #17**

*The BC government and Health Authorities, in collaboration with practising physicians, work towards the province-wide integration of health data, including central wait list registries to reduce and better manage wait lists. It is recognized that this will require additional IT funding from government and health authorities.*

**Recommendation #18**

*The BC government provide incentives for hospitals and physicians to reduce wait times in the province, conditional on both a decrease in wait times and an increase in services delivered.*

**Recommendation #19**

*Strategies be developed jointly by the BCMA and the BC government to improve the interface between primary and specialist care in an attempt to reduce and better manage wait lists.*

**Improving Accountability****Recommendation #20**

*Governments, Health Authorities and physicians develop standardized approaches and definitions, supported by appropriate information systems, to measure how long patients are actually waiting for surgical and diagnostic procedures.*

**Recommendation #21**

*The BC government and Health Authorities report accurate wait list times in a clear and concise manner to patients and health care providers on a monthly basis. Total wait times should be measured from time of GP referral to the provision of the service.*

**Recommendation #22**

*The Performance Agreements between the BC government and Health Authorities include specific wait time benchmarks with incentives to meet performance targets as well as disincentives for failing to meet targets.*

**Recommendation #23**

*A joint BC Wait Times Commission (BCWTC), comprising representation from the BCMA, BCNU, Ministry of Health and Health Authorities, be established to make recommendations regarding targeted wait time funding.*

**Recommendation #24**

*The BCWTC be responsible for monitoring the progress of all wait list initiatives in the province to ensure that wait times are consistent with medically reasonable levels.*

**Recommendation #25**

*The BCWTC report annually on the performance at meeting the medically reasonable benchmarks, as well as make recommendations on how to improve patient access to timely care.*

**Funding****Recommendation #26**

*The BC government provide the necessary funding to ensure that the citizens of BC have equitable access to necessary medical services regardless of geographical location.*

**Recommendation #27**

*Targeted funding be provided to bring BC into compliance with wait time benchmarks.*

**Recommendation #28**

*A significant portion of the 2004 Federal-Provincial Ten Year Health Plan funding be used to clear existing backlogs and increase the capacity of the acute care sector.*

**Recommendation #29**

*The BC government increase the percentage of service-based funding to Health Authorities, as an incentive to reduce wait lists.*

## APPENDIX B

### Principles for Establishing Medically Acceptable Wait Time Benchmarks (WTA, 2005)

1. Canadians have a right to timely and high-quality care beginning with access to a family physician or general practitioner (FP/GP).
2. Wait-time benchmarks must be developed from the patient's perspective, with patients involved in the development of benchmarks.
3. The development and setting of wait time benchmarks should be based on a pan-Canadian approach. Targets, however, should be set at a provincial or territorial level recognizing their different needs and capacities.
4. Wait time benchmarks should be based on the best available evidence along with clinical consensus.
5. Wait-time benchmarks are dynamic and should be derived in an ongoing and transparent process that involves evaluation, timely updating and a refinement of benchmarks when necessary.
6. Successful development, improvement and implementation of wait time benchmarks require the early, ongoing and meaningful input of the practising community.
7. Public accountability, through the monitoring and reporting of wait times, is exceedingly important to maintain patients' confidence in the health care system.
8. Wait time benchmarks and any associated provincial targets to reduce wait times must be sustainable. This will require a commitment to ongoing targeted funding through the Wait Times Reduction Fund.
9. The development of wait time benchmarks for the five priority areas must not be achieved at the expense of reduced access to other health care services.
10. Wait time benchmarks must be implemented with the use of appropriate guidelines and prioritization tools that are fair, equitable and transparent to the patient.



## APPENDIX C

### Actual Wait Times for Selected Treatments, Selected Provinces – Public Web Site Information as of December 2005 (Health Council of Canada Annual Report: 2005)

	Cardiac surgery	Radiation therapy	Cataract surgery	Hip replacement	Knee replacement
<b>Common benchmark* (time within which care should be provided)</b>	(Bypass only, by level of urgency) Level I: 2 weeks Level II: 6 weeks Level III: 26 weeks	4 weeks from being ready to treat	16 weeks for patients who are at high risk	26 weeks	26 weeks
British Columbia	Median wait: 10.4 weeks <i>Aug-Oct 2005</i>	Median wait: 0.9 weeks <i>Aug-Oct 2005</i>	Priority 2 & 3 cases: median wait 1.0–52.9 weeks <i>Aug-Oct 2005</i>	Priority 2 & 3 cases: median wait 2.1–102.7 weeks <i>Aug-Oct 2005</i>	Priority 2 & 3 cases: median wait 2.4–116.2 weeks <i>Aug-Oct 2005</i>
Alberta	(Bypass only) Median wait: 3.9 weeks  (% of cases done) 46.1% in < 3 weeks 19.3% in 3–6 weeks 27.2 % in 7 weeks–3 months 5.6% in 4–6 months 1.8% in 7–12 months <i>Aug-Oct 2005</i>	(Breast and prostate cancer)  2–5 weeks from referral to appointment with oncologist; < 2–3.5 weeks from appointment to therapy <i>As of Oct 31, 2005</i>	Median wait: 10.9 weeks  (% of cases done) 3.5% in < 3 weeks 12.2% in 3–6 weeks 48.8% in 7 weeks–3 months 23.7% in 4–6 months 8.1% in 7–12 months 2.9% in 13–18 months <i>Aug-Oct 2005</i>	Median wait: 18.0 weeks  (% of cases done) 7.9% in < 3 weeks 12.5% in 3–6 weeks 27.1% in 7 weeks–3 months 25.8% in 4–6 months 18.6% in 7–12 months 5.8% in 13–18 months 2.3% in 18+ months <i>Aug-Oct 2005</i>	Median wait: 23.9 weeks  (% of cases done) 3.2% in < 3 weeks 7.4% in 3–6 weeks 24.3% in 7 weeks–3 months 24.9% in 4–6 months 26.4% 7–12 months 9.2% in 13–18 months 4.6% in 18+ months <i>Aug-Oct 2005</i>
Manitoba	(Bypass only) Median wait: 25 days <i>Jul - Sep 2005</i>	Median wait: 1 week <i>Jul - Sep 2005</i>	not posted	not posted	not posted
Ontario	(Bypass only) Median wait: 14 days 90% cases done in 49 days <i>Aug-Sep 2005</i>	(Breast only) Median wait: 3.1–12.9 weeks <i>Jun-Aug 2005</i>	Median wait: 99 days 90% cases done in 311 days <i>Aug-Sep 2005</i>	Median wait: 119 days 90% cases done in 351 days <i>Aug-Sep 2005</i>	Median wait: 147 days 90% cases done in 440 days <i>Aug-Sep 2005</i>
Nova Scotia	Average waits: In-House Urgent done in 3 days; Semi-Urgent A done in 28 days; Semi-Urgent B done in 67 days; Elective done in 187 days <i>Oct 2005</i>	Average waits: (Capital Health & Cape Breton regions) Emergency done in 1 day; Urgent done in 7 & 5 days; Semi-urgent done in 21 & 20 days; Less urgent done in 36 & 32 days <i>Oct 2005</i>	% cases done: 33% in 30 days 54% in 60 days 67% in 90 days 90% in 180 days 95% in 270 days 99% in 360 days <i>Jan-Jun 2005</i>	% cases done: 7% in 30 days 15% in 60 days 26% in 90 days 49% in 180 days 63% in 270 days 75% in 360 days <i>Jan-Jun 2005</i>	% cases done: 4% in 30 days 9% in 60 days 17% in 90 days 40% in 180 days 57% in 270 days 74% in 360 days <i>Jan-Jun 2005</i>
Saskatchewan	(Bypass only) Median wait: 4 days <i>Apr-Sep 2005</i>  % cases done: 32% in 24 hours 46% in 24 hours–3 weeks 7% in 4–6 weeks 13% in 6 weeks–3 months 2% in 4–6 months <i>Apr-Sep 2005</i>	Median wait: 3.2 weeks from first appointment with oncologist to start of treatment <i>Apr 2004–Mar 2005</i>	Median wait: 21.9 weeks <i>Apr-Sep 2005</i>  % of cases done: 2% in 24 hours 9% in 24 hours–3 weeks 9% in 4–6 weeks 15% in 6 weeks–3 months 24% in 4–6 months 28% in 7–12 months 9% in 13–18 months 3% in > 18 months <i>Apr-Sep 2005</i>	Median wait: 14.4 weeks <i>Apr-Sep 2005</i>  % of cases done: 20% in 24 hours 3% in 24 hours–3 weeks 5% in 4–6 weeks 18% in 6 weeks–3 months 20% in 4–6 months 16% in 7–12 months 7% in 13–18 months 11% in > 18 months <i>Apr-Sep 2005</i>	Median wait: 40.3 weeks <i>Apr-Sep 2005</i>  % of cases done: 1% in 24 hours 1% in 24 hours–3 weeks 3% in 4–6 weeks 9% in 6 weeks–3 months 20% in 4–6 months 24% in 7–12 months 9% in 13–18 months 32% in > 18 months <i>Apr-Sep 2005</i>

\*The provinces and territories announced these common benchmarks on December 12, 2005.

## APPENDIX D

### 10 Steps Suggested Toward a Common Framework for Reporting on Wait Times (Health Council of Canada)

1. Where comprehensive wait time management does not yet exist, Health Ministries should choose a representative basket of procedures on which to report wait times in a way that minimizes the risk of inadvertently increasing waits for other procedures. The long-range goal should be to address wait times on all health care interventions.
2. Enrollment on a wait list should take place at the time the intervention is formally booked (usually by a specialist). Both the original date of referral to the specialist and the booking date for the intervention should be recorded. The waiting interval should be defined as the time from initial referral to completion of the procedure.
3. Provincial and territorial jurisdictions should designate a working group charged with the task of defining a common minimum dataset for reporting on wait times and producing a model for reporting that meets the needs of the Canadian environment.
4. Cases should be prioritized on basis of urgency in a system using no more than three levels of priority.
5. The term urgency level should be adopted (rather than priority) to indicate that the score refers only to timeliness required and does not constitute a judgment on the degree of need.
6. Provinces and territories should choose benchmarks for wait times for all urgency levels, and these benchmarks should include targets for percentages of cases that should be completed within the benchmark times.
7. Jurisdictions should use percentiles to report on the distribution of wait times. This should replace the practice of quoting averages or medians.
8. Jurisdictions should further agree to:
  - a. For reporting purposes, omit cases with the highest urgency (e.g., emergency) and instead report separately on Level 2 and Level 3 cases.
  - b. Use date of original booking request as the start date (in addition to the referral date) no matter how many times the case is rescheduled.
  - c. Track the number of and reasons for cancellations or re-bookings as part of the minimum dataset.
9. Jurisdictions should make it a matter of policy to calculate capacity requirements for both elective and emergency cases based on their best estimates of projected need.
10. Until some other method has been validated by actual practice, historical utilization patterns should be accepted as the best estimate of current need for the purposes of capacity calculation.

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