# The Taming of the Queue II: Wait Time Measurement, Monitoring and Management

Colloquium Report

March 31-April 1, 2005
Ottawa, Ontario

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Prepared by:
Tom McIntosh, PhD
Director, Health Network
Canadian Policy Research Networks

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### Members of the Steering Committee

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Ms. Martha Hall
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Ms. Brenda Trepanier
Mr. Greg Webster
Dr. David Zussman

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# DAY ONE

## Introduction

Wait times and related issues of access to necessary health care services continues to be one of the key concerns of governments, health system managers, health professionals of all types, policy analysts and, of course, the general public. The September 2004 meeting of First Ministers in Ottawa made reducing wait times for key procedures a priority for governments and the federal government offered significant funds to the provinces to continue their work on managing and reducing the wait-times for patients in those areas.

Yet the move to tackle wait-times should not be seen as a top-down process being driven in the main by political actors. The First Ministers commitment of both funding and attention to the issue came at a time when jurisdictions across the country were already implementing wait-time reduction strategies that were themselves the culmination of sometimes years of detailed study and analysis of the complex range of factors that can contribute to unacceptably long waits for necessary surgical and other medical (usually diagnostic) procedures.

It was within this context that nearly 150 participants gathered in Ottawa to discuss, debate, analyze and share experiences with issues relating to wait time management and reduction. The Taming of the Queue II symposium gathered a broad mix of government representatives, health policy analysts, health professionals and stakeholder organizations in an effort to assess the progress being made, the challenges that still existed, the latest research developments and the future plans for wait list management. This second iteration of the symposium differed markedly from the first event held exactly a year earlier in Aylmer, Quebec (cf. CPRN 2004).

As the symposium co-chair, David Naylor, noted in his opening remarks, a great deal had changed in the course of a single year. Whereas the first conference was focused on the underlying factors that contributed to wait time growth and looked to identify the multi-faceted strategies that would be needed to tackle this growth, this meeting was to be focused on the progress being made, fine-tuning the existing strategies in place and integrating the use of benchmarks and targets into the those strategies. The new federal money being made available for wait time initiatives was welcome, Naylor said, but he also recognized that it made provincial governments, system managers and health providers the 'meat in the sandwich' between the federal government and the public who as taxpayers foot the bill and, as patients, have expectations about what is reasonable and unreasonable when it comes to waiting for services.

These comments were further extended by Naylor's co-chair, Ginette Lemire-Rodger, who reminded participants that the issue of wait times could not be tackled in isolation from other challenges facing the health care system. As progress gets made in managing wait times, the need to contextualize those changes within the overall health reform agenda becomes more pressing. The reform of primary health care and the desire to move to greater interdisciplinary practice and collaboration will have implications for how long patients may wait for some services and it was important that policy-makers, stakeholders and health professionals not miss this forest in their focus on the trees.

## Cross-country Check-up

Following a videotaped message of greeting from federal Health Minister Ujjal Dosanjh that emphasized that how governments dealt with wait times would be a key indicator of public perceptions of the effectiveness of the overall health care system, the conference turned to a province-by-province overview of government initiatives and progress on wait list management.

### British Columbia

Deputy Minister of Health Services Penny Ballem began with an overview of the increase in capacity that has been evident in B.C. in the past decade. At the same time, it is clear that there are still important challenges to be met. Of particular note, she pointed to these accomplishments:

- Development of a surgical registry based on the Saskatchewan model;
- Development of more rigorous and transparent data allows government to target funds to specific needs in terms of increasing capacity;
- 10% percent of waitlist surgery done within a week, 25% in less than two weeks, 50% done within a month, 75% within three months and 90% within seven months.

Ballem noted that the tails of the distribution (those small numbers of patients that wait unacceptably long times for surgeries) are of particular importance and that there is still work to be done on understanding why they occur. But the guiding principle for progress is to focus on wait lists within the context of the full continuum of care from promotion and prevention through to post-surgical home care and residential care.

The key enablers of this progress will be good data, a good understanding of what the data means and the appropriate infrastructure in terms of health human resources, information technology and capital.

### Alberta

Alberta's presentation (by Margaret King, Director, Quality and Accountability Branch, Alberta Health and Wellness) began with an overview of some of the past strategies employed by the government to deal with wait times, including both targeting funding to increase capacity for specific services and the setting of service targets. Unfortunately, the tendency for targeted funding to unleash pent-up demand within the system, especially for MRI scans and joint replacement surgeries meant that these initiatives had very limited impact.

Building on the recommendations of the Mazankowski Report (Alberta 2002) and the work of the Western Canada Wait List Project (WCWLP) and incorporating other initiatives that are ongoing (e.g. local primary care reform, electronic health records and alternative payment plans for doctor services, etc.) the Alberta government is working toward a comprehensive wait list strategy that includes:

- The Alberta Waitlist Registry
    - Public Web site went live in 2003, enhanced in 2004

    - Includes comprehensive public reporting of waitlists
    - Reports to regional authorities and public on a monthly basis
    - Plans for expansion to a wider range of services underway as well as enhancement to its stakeholder engagement capacity
- Access Standards
    - Health authorities developing standards for access in the areas of: major joint replacements, cardiac services, breast and prostate cancers, MRI and CT scans and children's mental health
    - Aim to develop standards of appropriate wait times for the majority of Albertans (90th percentile)
- Optimizing Access
    - Ongoing work to streamline the processes involved in accessing services from diagnosis to referral to treatment to post-treatment care

The key lessons identified from these activities were: 1) the need to ensure quality of care remains at the centre of the equation; 2) the need to keep the accountability model explicit (where do the standards apply, who leads, etc.); 3) high standards for data and data models; 4) effective engagement and support of stakeholders; 5) balance of provincial optimization and local solutions and 5) strong evaluation and monitoring.

## Saskatchewan

Dr. Mark Ogrady, Chief of Surgery for the Regina-Qu'Appelle Health Region, presented an update on Saskatchewan initiatives, with a particular focus on the ongoing developments of the Saskatchewan Surgical Care Network and current surgical access strategies. The development of the network was greatly influenced by the experience of New Zealand in wait list management and the Western Canada Wait List Project's development of priority assessment tools for surgical procedures.

In March 2004 the province announced a series of performance goals for the delivery of surgery services based on the priority of patient need. For example, 95% of those patients assessed as Priority I (highest) should have their surgery within 24 hours, while 80% of those assessed as Priority VI (lowest) should have surgery within 12 months. And all patients should have surgery within 18 months regardless of their priority.

The Saskatchewan Surgical Registry tracks patients booked for surgery in ten health regions. The Registry produces accurate reports that include:

- How many patients waiting;
- For how long;
- For what procedure
- For which surgeon
- At what level of priority

Surgeons are responsible for assessing patients and making the final determination of who will receive their next surgery. Health regions are responsible for their patients and managing surgical access either through effective scheduling, patient flow and the management of the necessary human and financial resources.

The registry – combining accurate data and assessment according to need – represents a significant shift in the culture, responsibilities and processes for the department, regions and surgeons. Increased efficiency in the management of waitlists must also go along with increasing capacity within the system where it is appropriate to do so. At the same time, it is going to be important to reward those health regions that do well in meeting targets for list management in order to encourage the regions that the investment of time and energy will have pay-offs.

## Manitoba

Pat Hosang, Executive Director, Regional Support Services, Manitoba Health presented developments in Manitoba. The overall provincial strategies to improve access and reduce wait times include:

- Partnerships and collaboration with key stakeholders
- Improving processes for list management
- Government investments in technology and infrastructure
- Investments in health human resources
- Improvements in information technology
- Improving information services for the public
    - EG: Access to wait times information through Web site: www.gov.mb.ca/health/waitlist/index.html

The government has articulated the following priority surgical areas: cancer, cardiac, cataracts and hip and knee replacements as well as access to diagnostic imaging (especially MRI and CT scans). Progress in each of these areas is marked by a series of ongoing developments reflective of the strategies outlined above. For example, by way of improving processes for list management, radiation therapy for cancer and cardiac surgery has been consolidated at one provincial site. New investments have been made in diagnostic imaging equipment, while strategies to facilitate recruitment and retention of personnel are developed to use existing equipment fully. The province has created a network of orthopaedic surgeons that has consolidated services in Winnipeg. Further, there is a plan to increase capacity in Winnipeg and in two rural sites for hip and knee replacement surgeries.

The province is engaged in the implementation and evaluation of the WCWLP's general surgery tool and child and adolescent mental health tool. It was noted that surgery wait times are not a particularly significant problem in the Winnipeg health region. At the same time, the province is evaluating the Child and Adolescent Mental Health assessment tool which appears to be useful.

## Ontario

Peter Glynn, a senior advisor to the Ontario government on its Access to Services and Wait Time Strategy outlined developments in Ontario over the past year. Of particular note was the fact that Ontario's wait list strategy (as well as its overall strategy for insuring adequate and equitable access to services) was taking place in conjunction with profound structural change within the provincial system.

The development of the Local Integrated Health Networks (a form of regionalization) will go ahead, but existing hospital and other related boards will remain. At present, there are over 2000 boards, five academic health centres, five northern boards and a series of special institutions in different parts of the province. All of these bodies have to be coordinated in various ways as the wait list strategy unfolds over the next 18 months as the province moves to meet its commitment to improve access to cancer surgery, selected cardiac procedures, cataract surgery, major joint replacements and advanced diagnostic scans by December 2006.

Glynn noted a clear line of development from the launch of the Ontario Cardiac Care Network to the development of the Saskatchewan Surgical Care Network to the Ontario Wait List Strategy, with each innovation building on the lessons and experiences of the previous innovation.

Phase II of the Wait List Strategy was launched in April 2005 and is set to be completed by March 2006. A number of ongoing initiatives that are key to this phase's success are:

- The Institute for Clinical Evaluative Sciences (ICES) is undertaking a thorough going review of access in the five areas noted above including volumes, rates and wait times;
- New Information Management Processes, including:
    - A framework and the requirements for a provincial wait time information system;
    - Consistent tools for priorizing patients according to need in each of the five service areas;
    - Publicly available, accurate and standardized wait time information for the public via a Web site
- Improving surgical standardization and efficiency by identifying successful clinical innovations that can lead to more efficient practice and patient management;
- Developing a plan for access to MRI and CIT scans through an expert panel expected to make recommendations by April 2005

## Quebec

Louise Turgeon from the Ministry of Health and Social Services and Micheline Gagnon from the Centre hospitalier universitaire de Québec presented a case study of how the introduction of new software has contributed to reducing wait times for radio oncology services in the province.

In addition to the four centres in Montreal, Quebec offers radio-oncology services in six other centres across the province. But each of these centres had their own procedures and protocols for managing patient access.

Using software dubbed SGAS, and beginning in pilot sites, Quebec has been able to standardize the assessment of patients along a common grid of priority and establish a common standard as to when the patient begins their wait for service (referred to as the Date the Patient is Medically Ready for the needed service). Using this information, SGAS can establish the length of the patient's wait and can establish the date of the procedure for the patient. There are,

though, still challenges insofar as the system is not always able to provide a procedure date within the guidelines of what is an acceptable wait for a patient in a particular state of need.

But the system has accomplished some important tasks:

- Standardized definitions of 'waiting' across sites;
- Standardized assessment of need of patients;
- Reliable data for decisions regarding treatment

The government of Quebec is currently exploring the possibility of using the SGAS software and processes in other health service areas where wait times are a serious concern.

## New Brunswick

Recent studies have shown that wait times for surgery and specialist visits in New Brunswick are higher than the national average, while wait times for diagnostic tests are below the national average. According to Cheryl Hansen (NewBrunswick Department of Health and Wellness), the province's challenges with managing wait times are complicated by its relatively small and dispersed population, its proportionately larger rural population and the requirement that it deliver services in both official languages.

The Provincial Health Plan provides the basis for the province's wait times strategy with the overall goal of creating a patient-focused community-based integrated system. The provincial wait times and access strategy is set to begin in the 2005/06 fiscal year and will include:

- Investments for a new cardiac catheterization lab in the NB Heart Centre in Saint John;
- Development of NB Cancer Care Network to coordinate and integrate the diagnosis, treatment and management of cancer care
- Development of a province-wide surgical registry, standardized assessment of patients and public reporting

One of the key principles of the Health Plan is that none of its objectives can be met in isolation of the others. In particular, issues of health human resource planning and utilization are key components to improving access and reducing wait times.

## Nova Scotia

Brenda Ryan (Information Products Development, Nova Scotia Health) indicated that the province's Wait Time Monitoring Project has moved from the initial work of its Steering Committee (which completed its work in early 2004) to the ongoing initiatives being developed by the Wait Time Advisory Committee. The Advisory Committee has a mandate to advise the Minister of Health on:

- Wait time issues
- The development of a province wide approach to the standardized data collection and reporting
- Publication of wait time information and strategies to reduce wait times

To date the province has instituted a series of new mechanisms to insure that it has accurate and timely data that will allow it to develop comprehensive strategies. These initiatives have focused broadly on:

- Referrals to specialists (including medical oncology, surgical specialities and wide range of other specialist consults)
- Diagnostic services (including both short term 'next available appointment' methods and the longer term use of electronic schedulers to capture and report data)
- Wait Time Web site has been tested in focus groups and is currently being revised and is expected to be launched this year following stakeholder consultations
- Surgical services wait time data will be captured using existing information systems and new information systems

## Prince Edward Island

P.E.I. faces some unique challenges as Canada's smallest province, insofar as many of the more complex surgical and treatment services it provides to its approximately 130,000 residents it does through the purchase of those services in neighbouring provinces. And though the province reports progress in the five areas identified as priorities in the First Ministers Accord of 2004, Keith Dewar (CEO of the Provincial Health Services Authority) focussed his comments on a very specific case study that represented a key challenge to the timely delivery of services in the province – the excessive wait times in an urban emergency department.

The Emergency Room of the Queen Elizabeth Hospital was facing an ever increasing number of admitted patients waiting for a bed in the ED which posed significant issues of patient safety, lack of patient confidentiality and dignity, as patients were lined up in beds in hallways.

Over the course of six months, the hospital eliminated the wait for a bed by:

- Establishing a 'transition unit' using previously closed beds and staffing with LPNs;
- Reducing length of stay in all medical beds, including the ED
- Setting a 'saturation point' at which point IABs must be moved out of the ED and into the holding unit;
- Giving priority access to long term care beds in the health region.

The overall result of these innovations was to reduce IAB's to a low of 45 per month and an overall reduction in length of stay, while staff morale improved.

## Newfoundland and Labrador

Regina Coady (Director of Planning and Evaluation for the Government of Newfoundland and Labrador) provided an overview of how the government of the province is using new funds committed in the FMM Accord to build on existing initiatives in each of the five key priorities outlined in the Accord:

- Cardiac Care
    - Wait times consistently exceeded accepted ranges for non-urgent cases and NL performs the highest rates of CABG per 100,000 population in the country
    - A wait list management system was established in the mid-1990s

    - FMM commitments of $1.2M will allow an increase in cardiac surgery and in echocardiograms
- Joint Replacement
    - No provincial wait time information system
    - Low rates per population of joint replacement surgery
    - FMM commitments of $2.6M will allow an additional 340 surgeries per year
- Cancer Care
    - No provincial wait time information system
    - A recent study noted high personal costs for travel, accommodation and drugs resulting from treatment
    - New monies ($3.75M) will expand access to chemotherapy, cancer surgery, etc.
- Sight Restoration
    - New monies will provide 150-200 Visudyne treatments per year, which are currently not an insured service
- Diagnostics
    - Overall, has better access to imaging units per capita than Canadian average, according to CIHI Reports
    - FMM commitments will expand imaging services across the field

### Summary and Discussion

A couple of interesting themes emerged from the cross-country check-up from provinces. First, there was significant diversity in progress across provinces that reflected that provinces were clearly at different states of development when it came to wait list management initiatives. Some were really just beginning to collect the data in a way that would allow them to move forward while other initiatives were already showing significant results in some of the key areas. Second, there was a significant willingness for and evidence of cross-jurisdictional learning. Provinces were watching developments in other jurisdictions closely and adapting innovations to their own circumstances where appropriate. There was also some evidence that suggests that the rural/urban split in a particular jurisdiction will be an important factor in designing initiatives, and it was clear that provinces were beginning to confront the reality that wait list issues can not be tackled in isolation from health human resource, information technology and primary care reform issues.

## Wait Time Indicators, Benchmarks and Targets

In opening the afternoon session, symposium co-chair David Naylor noted that while there was evidence of real progress being made at the "coal-face" with regard to wait times, the First Ministers Accord's commitment to establishing 'benchmarks and targets' for wait list management created a new research agenda and new data needs for researchers and governments.

The afternoon session was launched with an overview of the recent progress being made by the Canadian Institute of Health Information (CIHI) in filling the ongoing data gaps. CIHI Chief Executive Officer Glenda Yeates' presentation began with an acknowledgement that while

significant strides have been made in providing data to decision makers in a usable form, there were significant challenges with wait list data that remained:

- There are many possible "waits" for a patient receiving any particular treatment and many places where that data could be stored;
- Collection of the data requires collaboration from physicians and facilities;
- Success will require time, commitment and resources;
- There are real differences in the five priority areas in terms of volumes, the number of facilities involved and the nature of the care required which will make the data collection more complex.

By way of illustration Yeates pointed to a number of the key issues that need to be addressed:

- Data collection: where does it reside, what are the incentives for accurate and timely reporting, what are the processes for doing so;
- Measurement: when does the clock start and stop, who is included on the list, what precisely is the wait for and how meaningful are average waits;
- Surgery rates: how do we incorporate wait time information with information about differences in surgical rates;
- Outcomes: how do we incorporate outcomes information with the information on wait times (e.g. pre- and post-surgery health status information).

The focus for CIHI is to work with jurisdictions (who are all at different points in the development of strategies) to fill gaps in their data and to work toward consensus on definitions and standardization of data.

The first roundtable of the afternoon built on Yeates' overview by examining the progress of particular research initiatives aimed at collecting reliable data that would give decision makers the capacity to set benchmarks for wait times in key priority areas.

- Jack Tu (Senior Scientist, ICES) noted that there still exists a limited amount of high quality evidence and because that is likely to change in the near future, we must be open to all kinds of evidence while also keeping in mind the limitations that each kind of evidence has.
- Tom Noseworthy noted the challenges being faced in the latest work by the Western Canada Wait List Project in developing Maximum Acceptable Wait Times (MAWTs) for both cataract and joint replacement surgeries. Noseworthy stressed that the MAWTs currently developed by the WCWLP are still subject to important limitations given the data but that they are a step toward the setting of reliable evidence-based benchmarks and he warned that the work on benchmarks can be seriously undercut "when the politics of wait list management shows up at the table."
- CMA President-elect Ruth Collins-Nakai spoke to the work of the Canadian Wait Times Alliance's work on setting out "medically acceptable wait times" in the five priority areas. The Alliance, consisting of six national medical speciality organizations, has proposed acceptable wait times based on priority of need, but also notes that the process of consensus building amongst providers may be more important than the actual benchmark number produced and expressed some concern about how the focus on the five priority areas may compromise other services.

The second panel of the afternoon focused on the progress being made in those five priority areas articulated by the FMM Accord:

- Cardiac Surgery: Kevin Glasgow of the Cardiac Care Network of Ontario noted that the CCNO is the common ancestor of most wait list initiatives in the country and continues to make some progress. But he noted that resources are lagging behind system growth and that several key challenges remain to be solved including:
    - Different understanding of mandates between key actors and the fact that wait time reductions are not consistent across regions in the province.
- Cancer: Brent Schacter of the Canadian Association of Provincial Cancer Agencies noted that cancer treatment wait times were particularly complex because the disease and its treatment can take many forms and involve different combinations of health professionals. Drawing on work undertaken internationally as well as some domestic initiatives Schacter called for a national consensus conference on cancer wait time issues that would provide common definitions, standards and targets for cancer management.
- Diagnostic Imaging: George Murphy of Capital District Health in Halifax, Nova Scotia spoke to the unique challenges facing list management with specifically high-end diagnostic imaging. Because these procedures are themselves tools used to determine need for other services, managing wait times for them may require more attention paid to the supply-side of the equation. In particular, he noted that issues around health human resources, hours of operation for machines, and the highly politicized environment around imaging access, will need to be confronted for the limited benchmark work underway to proceed.
- Joint Replacement: Brenda Payne of the Nova Scotia Department of Health noted that benchmarking for joint replacement in the province was proceeding cautiously because of a number of factors. There was a need to better understand the process of care (both pre and post-surgery) which was currently poorly coordinated across the province and between districts and that while a maximum wait time of six months had been established it was not a benchmark as commonly understood. Work was ongoing on understanding the role of co-morbidities in joint deterioration with a current focus on prevention issues such as obesity and fall reduction among the elderly.
- Sight Restoration: Lorne Bellan of the University of Manitoba noted that the Canadian Ophthalmological Society recommends a maximum wait time of four months for cataract surgery (with quicker surgery for high priority patients) and argued that the first priority of new spending would be on getting new ophthalmologists into communities where personnel is lacking. In addition he noted the need for provincially centralized wait lists and a centralized priorization tool.

The first day of the symposium ended with presentations from Robert McMurtry and Les Vertesi, both members of the Health Council of Canada. For his part, McMurtry noted that the Council had made monitoring progress of wait list management a key focus of its ongoing work. The requirement of quantifying need was identified as necessary for planning capacity. For example, he noted the work of Hawker, Wright et al. which notes that there is demonstrable gap between those who could be objectively determined to need joint replacement surgery and those willing to undergo the procedure. Given that current rates of total joint replacement are a

fraction of those willing to undergo treatment, there may be a gap in the understanding of need in this and other targeted domains.

Reviewing evidence from other countries, as well as what has been learned across the country, he noted that it will be important to monitor the impact (both positive and negative) of the strategy of targeting priority areas, as opposed to taking a comprehensive approach. Furthermore, he noted that it was increasingly clear that wait times issues were inextricably linked to issues around health human resources, information technology innovations and capacity within the system.

A different perspective on wait lists was introduced by Vertesi's exploration of the relationship between wait times for elective procedures and the congestion that faces numerous emergency departments across the country. Vertesi noted that while ER congestion appears on the surface to have different causes and solutions than does elective wait list growth, he argued that they are in fact different aspects of the same problem – namely how we manage hospital admissions, both in terms of scheduled and unscheduled admissions (the latter consisting of both emergency admissions and transfers from other hospitals).

## Summary

If the first half of the day emphasized the progress that was being made in different jurisdictions (and the variability of that progress), then the second half made clear how much work remains to be done. The complexity of developing reliable and achievable benchmarks is unlikely to be unravelled over the short term, but there was a growing consensus on what was needed in order to make progress in terms of filling data gaps, developing priorization tools, considering various types of evidence and dealing with issues of capacity and technological and human resources.

## Day Two

# Queue-tips: Learning from the International Experience

While the first Taming of the Queue symposium provided an overview of wait list management issues across the Organisation for Economic Co-operation and Development (OECD), the second iteration chose to focus specifically on the experiences of three countries: Great Britain, New Zealand and the United States.

### *The U.K. Experience* (Sean Boyle, London School of Economics)

The attempts by the Labour government to deal with the burgeoning wait list problem in the National Health Service can be broken into three phases:

- 1997 – 2001:
    - Focus on the numbers of people waiting and driven by a political promise to remove 100,000 people from the list
    - Target met by 2000, but average wait times did not fall and out-patient lists grew although National Booked Admissions Program changed the way people thought about the overall system of delivery
- 2001 – 2005:
    - Change to a focus on reducing maximum wait times and removing long waits from the lists
    - Increased funding included more specialists and independent treatment centres that ringfenced beds for elective care from those used for emergency care
    - Expanded role for the private sector
    - By mid-2004 wait lists were shrinking and the time targets were being hit, but median wait times fell slowly
    - Capacity increase and system redesign were the key to success
- Current:
    - Focus shifting now to the whole wait for treatment – the amalgamation of different waits at different points in the treatment continuum
    - Target is to reduce wait from GP visit to treatment to 18 weeks
    - Results include increasing patient choice, hospitals 'paid by results', and increased capacity and sharing of learnings are positive
    - Still needs to take into account productivity of provider issues and the better development of priorization tools, and need not only better information for the whole system, but especially information regarding population sub-groups
    - Not clear that access is improving for some sub-groups of the population, and the ability to 'game' the system by providers and patients is still a concern

### *New Zealand* (Ray Naden, consultant to the New Zealand Ministry of Health)

The New Zealand Government has set the following objectives for access to elective services:

- Maximum wait time of six months for first specialist assessment
- Surgery within six months if patient has a level of need that can be met within the resources available in the system

- Equity of access regardless of where patients live
- Delivery of a level of services sufficient to assure access before patients reach a state of unreasonable distress, ill health or incapacity

Meeting these objectives has required an increased level of transparency to patients so that they know clearly what their need is, whether that need falls within the threshold for service within the public system and, if it does, when the service will be provided.

It is also necessary to provide care to those who do not meet the threshold for surgery after their initial assessment. These patients are not removed from the system, but rather placed within a different process that continues to monitor their condition. The greater clarity about what is available and what is not within the public system allows those with private insurance to decide whether they wish to purchase surgery privately. The public system quite explicitly rations the number of services it provides on the basis of the overall financial sustainability of the system. The routine use of prioritization tools to assess patient need relative to others across the public system is making the provision of access more equitable. The level of service the system can provide is becoming more explicit, which better informs political debate on the issue of access to publicly funded elective services.

### *The United States* (William F. Feeley, U.S. Department of Veterans Affairs)

The U.S. Veterans Health Administration currently has 5.1 million patients across the country, an increase of 104% since 1995. It provides a fully integrated range of health services through a vast network of sites-of-care, hospitals and medical centres and clinics. Patients tend to be older, sicker and poorer than the national averages.

Long wait times for appointments, especially for new patients, led to increased veteran dissatisfaction with the system and ultimately led to a political directive from the US Congress to "fix" the problem.

The VHA introduced a new approach to clinic management to balance supply and demand using advanced informatics and physician leadership. Pilot projects designed to meet targets with rapid spread of successful innovations across the system and widespread use of regular reporting, clear accountability measures and rewards for performance. Of particular importance was the role of 'champions' at all levels of the system, from clinics to facilities to regions to the national level. The system currently treats more patients with measurably better outcomes than was the case a decade ago and patient satisfaction has increased significantly.

## Discussion and Summary

Each of the international case studies presented demonstrated the range of different kinds of wait list problems that exist and demonstrated that there is no single set of solutions to tackle them. All three presentations also point out the highly political nature of the wait time issue in these countries, something very familiar to Canadian audiences. Both the U.K. and the U.S. experiences were 'kick-started' by political pressure from above, while the New Zealand process has made public capacity issues increasingly political in light of the increased transparency over what the threshold for treatment within the public system is. Questions were asked as to the ability or tendency for patients or providers to 'game' the system in some way to move up the

wait list. Boyle admitted there was a problem in parts of the U.K. system with this and that without national data it is difficult to deal with. Naden noted that there is little evidence of it in the New Zealand case, but it was a concern with providers who operate in both the public and private system. All three presenters noted that the priorization processes being implemented have not yet been fully implemented with regard to diagnostics, although they are exploring different avenues for movement in this area.

## A Systems Perspective on Wait Time Reduction

Michael Carter (University of Toronto) demonstrated how 'queueing theory' can be applied to at least some kinds of health care queues. In its simplest form, queueing theory can, with knowledge of arrival and service rates, predict the average length of time a person will wait, but most health care queues are not akin to other queues we experience (such as those at an automated teller machine). Thus the models need to be increasingly sophisticated to take into account that patients are not, in some settings, served on a first come first served basis, and that some patients' treatment involves a complex network of queues involving different aspects of their care. However, the modelling is now increasingly sophisticated to deal with various 'what if' scenarios that can help to predict future impact of changes, such as increases in capacity, more efficient use of resources, better scheduling, etc.

More generally, Carter's analysis points to the need for wait list management tools and strategies to take an increasingly holistic approach to the problem by focusing on the patient's needs. If the patient is placed at the centre of the analysis, then it becomes possible to understand the network of waits they experience in a manner that can give some insight into how they can minimized to acceptable levels. Patients must also be given the information that would allow them to fully understand their wait times, and need to be assisted through their wait.

Dr. Alain Pavilanis (President of the College of Family Physicians of Canada) provided a somewhat different perspective on how to measure wait times. Whereas most reports and systems in place define the beginning of the wait time as that moment when the patient sees a specialist and is waiting for definitive care, Pavilanis argued that wait times should be calculated from the moment the patient seeks initial medical attention from a primary care physician. Pavilanis noted that this is how the public perceives the beginning of their wait time (citing work by Decima Research), and it would emphasize the importance of the current shortage of family physicians as a factor in wait time growth.

The Capital Health Region in Edmonton, Alberta is a case study of how ever increasing pressure on emergency rooms in the region necessitated a multifaceted approach. Ken Gardener (Vice President, Medical Affairs at Capital Health) noted that the number of emergency rooms visits had nearly doubled between 94/95 and 99/00 and that average wait times for inpatient beds through the emergency department was about six hours, but that over 1500 patients every year waited more than 24 hours. The solution was two pronged, aiming at both demand and throughput:

- Establishment of a telehealth link, staffed by RNs, providing advice and support to patients who might otherwise visit emergency rooms, has resulted in an actual decrease in non-urgent ED visits.

    - Investements in education campaigns has heightened awareness and use by the public
- Establishment of an Emergency Inpatient Holding Unit to provide a pressure release valve for overburdened emergency rooms has resulted in:
    - Improved throughput, higher patient satisfaction and earlier initiation of inpatient care process and fewer ambulance diversions because of lack of space

The final presentation in this session again focused on the need to take a more holistic approach to the problems confronting the system. Marian Walsh (Bridgepoint Health, Toronto) noted that the key challenge was managing chronic conditions and the growing number of Canadians with multiple chronic conditions. Noting that wait list management was important, Walsh went on to argue that it should not be seen as "transformational" change and it is that which is needed.

## A Future Research Agenda on Wait Times

The afternoon session began with a facilitated dialogue with symposium participants led by Morris Barer (Scientific Director, Institute of Health Services and Policy Research, Canadian Institutes of Health Research) and Jonathon Lomas (Chief Executive Officer, Canadian Health Services Research Foundation).

Barer opened the session by reflecting on both the degree of progress made in dealing with wait lists since the last symposium and the greater understanding we have of the gaps in our knowledge stemming from the presentations over the previous day and a half. He also outlined some of the recent initiatives at CIHR intended to fill some of those gaps, including the recently-posted rapid-response "Wait Time Benchmarks" RFA intended to provide information of use to the P/T Deputy Ministers of Health in development benchmarks in the five clinical areas identified in the 2004 Ten Year Plan.

In reviewing some of the recent synthetic work of the CHSRF, Lomas noted that wait list research will require a mix of two types of evidence:

- Scientific evidence (some of which is largely context free and concerns clinical outcomes, some of which is sensitive to and directly addresses the context factors surrounding implementation of wait list management strategies)
- Colloquial evidence that consists of professional opinion, political judgement and pragmatic possibilities about what can be done.

What is needed, he argued, is a deliberative process that can reconcile both kinds of evidence in a manner that protects scientific evidence's validity, while recognizing the importance of colloquial evidence in making real life decisions and policy choices.

What followed was an open mike session that allowed symposium participants to articulate research areas and research questions that still need to be addressed in order to move the process of wait list management forward. The ideas presented tended to fall into some board categories:

## A. Patient Focused Research:

a. Patients used to have the choice of which specialist to see; efforts to 'rationalize' wait lists to deal with some of the problems associated with individual-physician-controlled lists seem destined to eliminate any choice flexibility for patients as they're sent to the shortest list. Is there some way to measure the value patients put on retaining choice of specialist, and to factor choice into the study of wait lists/times and the determination of benchmarks and optimal wait times?
b. How do we go about understanding and taking account of the attitudes and expectations of patients on wait lists? New processes of dealing with waiting have to include coming to grips with the expectations of patients, but we don't know very much about these. We know very little about the people on lists, what their attitudes are towards risk and how they assess the trade-offs associated with waiting.
c. We lack any good information on the role of uncertainty for patients on lists. Would they be more willing to be on lists if they had a greater degree of certainty about the length of the wait, and a better idea of the likely impact of the wait on their health, quality of life, and long-term prognosis? What do the certainty/time trade-offs look like (e.g. if patients need to wait a bit longer in order to have more certainty, where would they land on this tradeoff framework?)
d. Consideration should be given to funding a large cohort study of the risk in each of the priority areas and to see if outcomes are changing as a result of the focus on these areas
e. Design RCTs of different approaches to managing wait lists, or of application of different tools (e.g. could randomize regions to use and not to use benchmarks, or centralized patient registries, or to use different prioritizing tools); then could follow cohorts of patients in each region, pre- and post-waits.

## B. Wait List Management Research:

a. There is a lot of work that could usefully be done in refining the tools we use to measure the impact of waiting (e.g. quality of life and outcomes assessment tools)
b. There has historically been too much emphasis placed on a few high-profile diseases, which have also been painted rather broadly (as in the Ten Year Plan). There has also been too much emphasis placed on acute care "waiting", and too little on the lack of coordination, e.g., in the management of chronic co-morbidities
c. There is a considerable amount of natural variation, and therefore experimentation, within the system already. What is the impact for patients and providers of the different approaches to list management already being used? And can we extend that understanding through modelling of other variations?

## C. Health Human Resources Research:

a. There is a need to deal with the health human resources issues that are at the heart of some of the wait list questions. For example, how would effective integration of HHR across the continuum of care affect different segments of system waiting? How much of the waiting in the system is a function of variability in productivity of HHR, and how much is a function of non-human physical resource constraints?
b. Use modelling to examine the impact on waiting times of increases in numbers, and changes in methods of deploying, HHR
c. Do some modelling to look at the effects of population demographic change on waits for different types of procedures, given what we know about age-specific prevalence

and about future availability of HHR needed to undertake the procedures/services in question.

## Where To From Here?

The final session was billed as a 'fireside chat' between a group of health care analysts and moderated by CBC commentator Rex Murphy. Each was asked to reflect on the key things they had heard during the course of the two days:

David Zussman noted first that wait lists and the public preoccupation with them were indicative of not only how the debate has changed, but also how important metrics were becoming to public debate, leading him to note the growing importance of reporting and accountability in the public mind. But he went on to note how little attention was given to questions of accountability and governance throughout the symposium. Future iterations of the symposium might choose to emphasize the issue of technology as a force for system integration and issues around public expectations.

Pierre-Gerlier Forest picked up the theme of governance and noted that the Naylor report on the SARS outbreak was really about a failure of governance within the system and wait lists are also a governance issue. He further noted the need to move the discussion toward a more integrative approach to providing care and the need to confront the need for leadership within different parts of the system.

Tom Ward noted that wait times are but a symptom of a system that is ailing and we need to move beyond treating the symptoms. He called for the creation of a national health human resources observatory to provide neutral space for the difficult discussion of who will do what within the system. In addition he noted the need to come to grips with the information technology questions that are preventing more wholesale reform of the system.

Ida Goodreau also emphasized the need to take a more holistic approach that saw wait times as a symptom rather than as the problem itself. Benchmarks were important, but transformational change is needed in order to ensure a more coherent continuum of care.

Denis Morrice emphasized the need to allow patients and the public into the discussions. There was not going to be any serious ability to deal with patient expectations unless they had a seat at the table that decides on what the acceptable wait times are going to be.

In the open discussion that followed, a number of key points were raised:

- Wait times are themselves symptoms of other problems within the system including our inability to coordinate care effectively, capacity and resource problems and governance issues
- A need to involve citizens and patients in more fulsome discussions about the nature of wait times, and to ensure that patients are not left to wait on their own – that there be supports and ongoing assessments while they are waiting
- The need to discuss the possibility (and reality) of rationing within the system in an open and transparent manner with the public, in order that they understand the short fall between the clinical and financial thresholds for treatment

In their closing comments, co-chairs Naylor and Lemire-Rodger noted that there was ample fodder for a third iteration of the symposium to deal with a range of issues including:

- The need for public and patient input into the discussions
- The need to tie the discussion to questions of health human resources planning issues
- The need to tie wait list issues to the broader issues of health reform
- The need to continue the discussion of best practices from across the country, and to deal with both the reality of provincial asymmetry and the need for standardized forms of data collection and measurement.

# Appendix A: Final Agenda

**The Taming of the Queue II** / **Maîtriser les files d'attente II**

**The Westin Ottawa, Ottawa, ON** — **March 31 – April 1, 2005**

## THURSDAY, MARCH 31
**Room: Confederation III**

7:30 – 8:00 Registration and Continental Breakfast

***Setting the scene***

8:00 – 8:30 Welcome and keynote address – *David Naylor, Ginette Lemire-Rodger (co-chairs)*

***Improving access and reducing wait times: Are we making progress?***

8:30 – 10:15 Cross-country check-up on provincial and territorial developments – Penny Ballem (BC); Margaret King (AB); Mark Ogrady (SK); Pat Hosang (MB) Peter Glynn (ON); Moderator: Rex Murphy

10:15 – 10:30 Break

10:30 – 12:00 Cross-country check-up on provincial and territorial developments (cont.) – Louise Turgeon & Micheline Gagnon-Pilote (QC); Cheryl Hansen (NB); Brenda Ryan (NS); Keith Dewar (PEI); Regina Coady (NL); Moderator: Rex Murphy

12:00 – 1:00 Lunch in Confederation I

***Moving the First Ministers' agenda forward: wait time indicators, benchmarks and targets***

1:00 – 1:30 Reducing the wait for wait times data *Glenda Yeates*

1:30 – 3:00 Evidence, opinion and expectations – perspectives on the development of maximum acceptable wait times
- Institute for Clinical Evaluative Sciences – *Jack Tu*
- Western Canada Wait List Project – *Tom Noseworthy, Claudia Sanmartin*
- CMA/national specialty societies – *Ruth Collins-Nakai*

3:00 – 3:15 Break

3:15 – 4:30 Panel discussion: the art of the possible: reducing wait times in priority areas
- Heart – *Kevin Glasgow*
- Cancer - *Brent Schacter*
- Diagnostic Imaging – *George Murphy*
- Joint replacement - *Brenda Payne*
- Sight restoration - *Lorne Bellan*

4:30 – 5:00 The view from the Health Council of Canada – *Robert McMurtry, Les Vertesi*

6:30 Reception and dinner in Provinces I & II – *Keynote address by Rex Murphy*

## FRIDAY, APRIL 1
**Room: Confederation III**

7:30 – 8:00 Continental Breakfast

***Queue-tips: learning from international experience***

8:00 – 8:05 Opening comments - *David Naylor, Ginette Lemire-Rodger (co-chairs)*

8:05 – 8:45 Reducing wait times in the UK – *Sean Boyle*

8:45 – 9:30 A look at the New Zealand experience – *Ray Naden*

9:30 – 10:15 Managing wait times and access for veterans health care in the US – *William Feeley*

10:15 – 10:30 Break

***Reducing wait times – taking a systems perspective***

10:30 – 11:00 What do operational research and industrial engineering have to offer? – *Michael Carter*

11:00 – 12:00 Perspectives on managing demand and addressing bottlenecks across the system – *Alain Pavilanis, Ken Gardener, Marian Walsh*

12:00 – 1:00 Lunch in Confederation II

***Towards a research agenda on wait times***

1:00 – 2:00 Mapping out a responsive and forward-looking research agenda on wait times *Morris Barer, Jonathan Lomas*

***Where to from here? Moving the yardsticks forward on wait time reduction.***

2:00 – 3:30 Setting future directions: a fireside chat – *Rex Murphy (moderator)*
*David Zussman (rapporteur)*
*Pierre-Gerlier Forest*
*Tom Ward*
*Ida Goodreau*
*Denis Morrice*

3:30 – 3:45 Closing remarks - *David Naylor, Ginette Lemire-Rodger (co-chairs)*

Adjournment

**The Taming of the Queue Secretariat/**
**Secrétariat *Maîtriser les files d'attente***
1867, prom. Alta Vista Dr.
Ottawa ON K1G 3Y6
613 731-8610 or/ou
800 663-7336 ext./poste 2163
Fax/Télecop. : 613 731-1779

- Association of Canadian Academic Healthcare Organizations
- Canadian Health Services Research Foundation
- Canadian Healthcare Association
- Canadian Institute for Health Information
- Canadian Institutes of Health Research
- Canadian Medical Association
- Canadian Nurses Association
- Association canadienne des institutions de santé universitaires
- Fondation canadienne de la recherche sur les services de santé
- Association canadienne des soins de santé
- Institut canadien d'information sur la santé
- Instituts de recherche en santé du Canada
- Association médicale canadienne
- Association des infirmières et infirmiers du Canada

## Appendix B: Participant List

**Taming of the Queue II**
**March 31st – April 1st, 2005**

| | | |
|---|---|---|
| Mr. Owen Adams | Canadian Medical Association | Ottawa, ON |
| Dr. Andrew Affleck | Canadian Association of Emergency Physicians | Ottawa, ON |
| Ms Peggy Ainslie | Health Canada | Ottawa, ON |
| Ms. Meena Ballantyne | Health Canada | Ottawa, ON |
| Dr. Penny Ballem | B.C. Ministry of Health Services | Victoria, BC |
| Dr. Morris Barer | Institute of Health Services and Policy Research | Vancouver, BC |
| Mr. Louis Barre | Manitoba Health | Winnipeg, MB |
| Dr. Rob Beanlands | University of Ottawa Heart Institute | Ottawa, ON |
| Dr. Lorne Bellan | University of Manitoba | Winnipeg, MB |
| Mr. Jean-Marie Berthelot | Statistics Canada | Ottawa, ON |
| Mr. Seán Boyle | London School of Economics | London, UK |
| Mr. Glenn Brimacombe | Association of Canadian Academic Healthcare Organizations | Ottawa, ON |
| Dr. Michael Brundage | Canadian Association of Radiation Oncologists | Kingston, ON |
| Prof. Michael Carter | University of Toronto | Toronto, ON |
| Mr. Bob Cerniuk | VON Canada | Ottawa, ON |
| Mr. Mark Chase | Vancouver Coastal Health | Vancouver, BC |
| Mr. Howard Chodos | Library of Parliament | Ottawa, ON |
| Ms. Lisa Cirella | The Arthritis Society | Toronto, ON |
| Mr. Paul-Émile Cloutier | Canadian Medical Association | Ottawa, ON |
| Ms. Regina Coady | Newfoundland and Labrador Dept. of Health & Community Services | St. John's, NL |
| Dr. Ruth Collins-Nakai | Canadian Medical Association | Edmonton, AB |
| Mr. George Cooper | | Halifax, NS |
| Mr. Ron Corvari | Health Canada | Ottawa, ON |
| Ms. Linda Dacre | Privy Council Office | Ottawa, ON |
| Ms. Janet Davies | Canadian Nurses Association | Ottawa, ON |
| Mrs. Maura Davies | Capital District Health Authority | Halifax, NS |
| Dr. Ross A. Davies | University of Ottawa Heart Institute | Ottawa, ON |
| Dr. Carolyn DeCoster | University of Manitoba | Winnipeg, MB |
| Ms. Denise Desautels | Canadian Healthcare Association | Ottawa, ON |
| Mr. Keith Dewar | Provincial Health Services Authority | Charlottetown, PEI |
| Mrs. Lauren Donnelly | Saskatchewan Health | Regina, SK |
| Mr. Hubert Drouin | Canadian Ophthalmological Society | Ottawa, ON |
| Mr. Patrick Dumelie | Regina Qu'Appelle Health Region | Regina, SK |
| Dr. David Elliott | Nova Scotia Health | Halifax, NS |
| Mr. Michael Epp | British Columbia Medical Association | Vancouver, BC |
| Mr. Nadeem Esmail | The Fraser Institute | Vancouver, BC |
| Mr. Will Falk | Capgemini Canada | Toronto, ON |
| Mr. William Feeley | U.S. Department of Veterans Affairs | Albany, NY USA |
| Mrs. Anne Ferguson | Canadian Cardiovascular Society | Ottawa, ON |
| Ms. Cathy Fooks | Health Council of Canada | Toronto, ON |

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|---|---|---|
| Ms. Pamela Fralick | Canadian Physiotherapy Association | Ottawa, ON |
| Mrs. Sherry Freake | James Paton Memorial Hospital | |
| Ms. Danielle Frechette | Royal College of Physicians and Surgeons of Canada | Ottawa, ON |
| Dr. Ken Gardener | Capital Health Authority | Edmonton, AB |
| M$^{me}$ Micheline Gagnon | Centre hospitalier universitaire de Québec | Québec, QC |
| Ms. Sylvie Gauthier | Health Canada | Ottawa, ON |
| Ms. Linda Gee | B.C. Ministry of Health Services | Victoria, BC |
| Dr. Paul Genest | Bell Canada | Ottawa, ON |
| Dr. Pierre-Gerlier Forest | Health Canada | Ottawa, ON |
| Ms. Susan Gillam | Western Regional Integrated Health Authority | Cornerbrook, NL |
| Dr. Kevin Glasgow | Cardiac Care Network of Ontario | Toronto, ON |
| Dr. Peter Glynn | Consultant | Kingston, ON |
| Ms. Ida Goodreau | Vancouver Coastal Health | Vancouver, BC |
| Dr. John Gray | Canadian Medical Protective Association | Ottawa, ON |
| Ms. Patricia Greenhalgh | Health Canada | Ottawa, ON |
| Ms. Terrine Greenwood | Government of the Northwest Territories | Yellownife, NT |
| Ms. Emily Gruenwoldt | Association of Canadian Academic Healthcare Organizations | Ottawa, ON |
| Dr. Karen Gulenchyn | Canadian Association of Nuclear Medicine | Hamilton, ON |
| Dr. Calvin L. Gutkin | College of Family Physicians of Canada | Mississauga, ON |
| Ms. Martha Hall | Health Canada | Ottawa, ON |
| Ms. Cheryl Hansen | New Brunswick Department of Health and Wellness | Fredericton, NB |
| Ms. Barbara Harris | The Conference Board of Canada | Ottawa, ON |
| Dr. Lydia Hatcher | Canadian Medical Association | Mount Pearl, NF |
| Mr. Greg Hein | Ontario Ministry of Health & Long-Term Care | Toronto, ON |
| Dr. Peter Hollett | Canadian Association of Nuclear Medicine | St. Johns, NL |
| Mrs. Patricia Hosang | Manitoba Ministry of Health | Winnipeg, MB |
| Dr. Kenneth Hughes | Canadian Orthopaedic Association | Richmond, BC |
| Dr. John Hylton | Canadian College of Health Service Executives | Ottawa, ON |
| Dr. Alain Jodoin | Canadian Orthopaedic Association | Westmount, QC |
| Ms. Beatrice Keleher-Raffoul | Association of Canadian Academic Healthcare Organizations | Ottawa, ON |
| Mrs. Margaret King | Alberta Health and Wellness | Edmonton, AB |
| Mr. Noel Kivimaki | Health Canada | Ottawa, ON |
| Mrs. Donna Klaiman | Canadian Association of Occupational Therapists | Ottawa, ON |
| Mr. Craig Knight | B.C. Ministry of Health Services | Victoria, BC |
| Ms. Sarah Kramer | Ontario Wait Time Strategy | Toronto, ON |
| Mr. Alastair Lamb | Kingston Regional Cancer Care | Kingston, ON |
| Mr. Gordon Taylor Lee | Health Canada | Ottawa, ON |
| Mr. Jonathan Lomas | Canadian Health Services Research Foundation | Ottawa, ON |
| Mr. John Lott | Kingston General Hospital | Kingston, ON |
| Dr. William MacKillop | Canadian Association of Radiation Oncologists | Kingston, ON |
| Dr. John Maxted | College of Family Physicians of Canada | Mississauga, ON |
| Ms. Helen McElroy | Health Canada | Ottawa, ON |
| Mr. John McGurran | Western Canada Wait List Project | Canmore, AB |

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|---|---|---|
| Dr. Tom McIntosh | Canadian Policy Research Networks | Regina, SK |
| Ms. Valoree McKay | Canadian Association of Emergency Physicians | Ottawa, ON |
| Dr. Robert McMurtry | Health Council of Canada | London, ON |
| Ms. Farah Mohamed | VON Canada | Markham, ON |
| Mr. Denis Morrice | Bone and Joint Decade | Toronto, ON |
| Ms. Kathleen Morris | Canadian Institute for Health Information | Toronto, ON |
| Dr. George Murphy | Capital District Health Authority | Halifax, NS |
| Mr. Scott Murray | Manitoba Health | Winnipeg, MB |
| Dr. Ray Naden | Health Services Consulting | Aukland, NZ |
| M. Robert Nadon | Quebec Medical Association | Montréal, QC |
| Dr. David Naylor | University of Toronto | Toronto, ON |
| Mrs. Kathleen Ness | Capital Health Authority | Edmonton, AB |
| Mrs. Marie-France Noël | McGill University Health Centre | Montréal, QC |
| Dr. Tom Noseworthy | University of Calgary | Calgary, AB |
| Dr. Mark Ogrady | Saskatchewan Surgical Care Network | Regina, SK |
| Dr. Alain Pavilanis | College of Family Physicians of Canada | Mississauga, ON |
| Ms. Brenda Payne | Nova Scotia Health | Halifax, NS |
| Ms. Jennifer Perzow | Health Canada | Toronto, ON |
| Mrs. Patricia Pilgrim | Health Care Corporation of St. John's | St. John's, NL |
| Mrs. Patricia Pinfold | Institute for Clinical Evaluative Sciences | Toronto, ON |
| Dr. Glen Roberts | The Conference Board of Canada | Ottawa, ON |
| Mrs. Louise Rosborough | Health Canada | Ottawa, ON |
| Mr. Morris Rosenberg | Health Canada | Ottawa, ON |
| Ms. Jillian Ross | Cancer Care Ontario | Toronto, ON |
| Dr. Charmaine Roye | Canadian Medical Association | Brantford, ON |
| Dr. Ginette Lemire Rodger | Ottawa Hospital | Ottawa, ON |
| Ms. Brenda Ryan | Nova Scotia Department of Health | Halifax, NS |
| Ms. Hélène Samson | Canadian Association of Nuclear Medicine | Ottawa, ON |
| Dr. Claudia Sanmartin | Statistics Canada | Ottawa, ON |
| Mr. Marcel Saulnier | Canadian Medical Association | Ottawa, ON |
| Dr. Murray Schachter | | Winnipeg, MB |
| Dr. Brent Schacter | Canadian Association of Provincial Cancer Agencies | Winnipeg, MB |
| Mr. Brian Schmidt | Provincial Health Services Authority | Vancouver, BC |
| Dr. Albert Schumacher | Canadian Medical Association | Windsor, ON |
| Ms. Susan Scrivens | Vancouver Coastal Health | Vancouver, BC |
| Ms. Sharon Sholzberg-Gray | Canadian Healthcare Association | Ottawa, ON |
| Dr. Sam Shortt | Queen's University | Kingston, ON |
| Ms. Rachel Solomon | Ministry of Health and Long-Term Care | Toronto, ON |
| Dr. Clayne A. Steed | Alberta Medical Association | Raymond, AB |
| Ms. Heather Stewart | Ontario Hospital Association | Toronto, ON |
| Ms. Ann Marie Strapp | Ontario Ministry of Health & Long-Term Care | Toronto, ON |
| Dr. Deborah Tamlyn | Canadian Nurses Association | Ottawa, ON |
| Mrs. Janet Templeton | Health Care Corporation of St. John's | St. John's, NL |
| Mr. William G. Tholl | Canadian Medical Association | Ottawa, ON |
| Mr. Darrell Thomson | British Columbia Medical Association | Vancouver, BC |
| Ms. Hanita Tiefenbach | Ontario Ministry of Health | Toronto, ON |
| Dr. Angela Todd | Canadian Pharmacists Association | Ottawa, ON |

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|---|---|---|
| Mrs. Louise Tremblay | Canadian Association of General Surgeons | Ottawa, ON |
| Dr. Jack V. Tu | Institute for Clinical Evaluative Sciences | Toronto, ON |
| M$^{me}$ Louise Turgeon | Ministère de la Santé et des Services sociaux | Québec, QC |
| Mrs. Christine Vanderloo | Privy Council Office | Ottawa, ON |
| Dr. Les Vertesi | Health Council of Canada | Vancouver, BC |
| Ms. Laura Visser | | Toronto, ON |
| Mrs. Joanne Walker | Ontario Wait Time Strategy | Richmond Hill, ON |
| Ms. Marian Walsh | Bridgepoint Health | Toronto, ON |
| Ms. Katherine Walters | Baffin Regional Hospital | Iqaluit, NU |
| Dr. Thomas F. Ward | Consultant | Toronto, ON |
| Mr. Greg Webster | Canadian Institute for Health Information | Toronto, ON |
| Dr. Rob Weiler | Saskatchewan Surgical Care Network | Regina, SK |
| Dr. Keith Willoughby | Health Quality Council | Saskatoon, SK |
| Ms. Maggie Wylie | Health Canada | Edmonton, AB |
| Ms. Armine Yalnizyan | Consultant | Toronto, ON |
| Ms. Glenda Yeates | Canadian Institute for Health Information | Ottawa, ON |
| Dr. Jennifer Zelmer | Canadian Institute for Health Information | Toronto, ON |
| Dr. David Zussman | EKOS Research Associates Inc. | Ottawa, ON |

## Appendix C: Participant Survey Results

A conference participant survey on waitlist issues was circulated at the Taming of the Queue II conference. About 36.5% of the 159 conference attendees completed the survey, which sought opinions on the current and future states of timely access to care in Canada, the barriers to such care, and the concept of evidence-based benchmarks of medically acceptable wait times. The respondents represented a good cross section of the types of professionals in attendance.

While almost a quarter (22.4%) of respondents indicated not enough attention is paid to the wait times issue, the majority of respondents (60.3%) felt the topic was given just about the right amount of attention, and many (65.5%) are also optimistic that the situation will improve over the next few years. About 29.3%, however, fear the situation will worsen.

Currently, concerns about primary care services and advanced diagnostic services were weighted the highest, scoring an average of 3.9 out of a maximum score of 5, though concerns are high across all areas of health care.

Of the many barriers that exist to address the waitlist issue, non-standard definitions and the collection and reporting of wait times as well as insufficient health human resources and infrastructure were weighted most significant (4.1/5).

In terms of relative weight given to different inputs in the development of wait time benchmarks, published studies were seen as the most important followed by clinical judgement and patient expectations.

Over 85% of respondents felt that wait times should be measured and reported the same way across the country and that benchmark should be established in the short term using the best available evidence and refined over time. These indicators should be linked to agreed upon urgency levels.

## Results: Taming of the Queue II
## Participant Survey

**1. Which of the following categories best describes your current area of work**

| n=58 | Percent |
|---|---|
| provision of health services | 22.4 |
| health administration | 24.1 |
| Research | 17.2 |
| Government | 15.5 |
| Other | 17.2 |
| no response | 3.4 |
| Total | 100 |

**2. Thinking about the broad range of issues confronting health care policy in Canada, would you say that the issue of wait times is currently being given too little, too much, or just about the right amount of attention it warrants?**

| n=58 | Percent |
|---|---|
| too little attention | 22.4 |
| too much attention | 13.8 |
| just about the right amount of attention | 60.3 |
| no response | 3.4 |
| Total | 100 |

**3. Do you think that timely access to health services will worsen, improve, stay about the same over the next few years?**

| n=58 | Percent |
|---|---|
| the situation will worsen | 29.3 |
| the situation will improve | 65.5 |
| there will be no change | 5.2 |
| Total | 100 |

**4. On a scale of 1 to 5 where 1 is low and 5 is high, please indicate the extent to which you are concerned about the state of timely access at the following service points:**

| n=58 | Mean |
|---|---|
| Concern about Primary Care Services | 3.9 |
| Concern about Hospital Emergency Room | 3.8 |
| Concern about Specialist consultation | 3.8 |
| Concern about Advanced Diagnostic Services | 3.9 |
| Concern about Acute Care Services | 3.6 |
| Concern about Post-Discharge Services | 3.8 |

**5. On a scale of 1 to 5 where 1 is not significant and 5 is very significant; please indicate to what extent you believe the following issues are significant barriers to addressing concerns about wait times?**

| n=58 | Mean |
|---|---|
| **Barriers: non-std definitions; collecting/reporting of wait times** | 4.1 |
| **Barriers: limited coordinated managment of access to hlth services** | 4.0 |
| **Barriers: lack of tools to help phys. prioritize pts according to urgency** | 3.5 |
| **Barriers: insufficient hhr and infrastructure to meet pt needs** | 4.1 |
| **Barriers: system policies & admin. practices that inhibit efficient use of existing resources** | 4.0 |
| **Barriers: limited access to chronic disease mgt & prevention programs** | 4.7 |
| **Barriers: service availability in rural vs. urban areas** | 3.2 |
| **Barriers: unrealistic patient expectations** | 2.9 |

**6. Based on 100 points, what weight would you assign to the following inputs for the development of evidence-based benchmarks of medically acceptable wait times.**

| n=49 | Mean |
|---|---|
| **Published studies** | 27.76 |
| **health system resources** | 14.71 |
| **resource implications** | 14.74 |
| **clinical judgement** | 18.15 |
| **patient experience/expectations** | 17.11 |
| **public views** | 8.88 |
| **other (please specify _____)** | 0.69 |

**Specified others include:**

comparable benchmarks in other countries

impact on quality of life of pt/family

**7. Do you agree or disagree with the following statements.**

| n=58 | agree | disagree | no response | Total |
|---|---|---|---|---|
| **Wait times should be measured and reported the same way across Canada** | 89.7% | 5.2% | 5.2% | 100.0% |
| **Benchmarks & indicators should be linked to agreed upon urgency levels** | 86.2% | 3.4% | 10.3% | 100.0% |
| **Benchmarks should be established in the short term with best avail. evidence & refined over time** | 87.9% | 3.4% | 8.6% | 100.0% |


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Canadian Policy Research Networks Inc.
600-250 Albert Street
Ottawa, ON K1P 6M1
Tel: (613) 567-7500 – Fax: (613) 567-7640 – Web site: www.cprn.org