CHALLENGES IN DEVELOPING NATIONAL BENCHMARKS FOR WAITING TIMES

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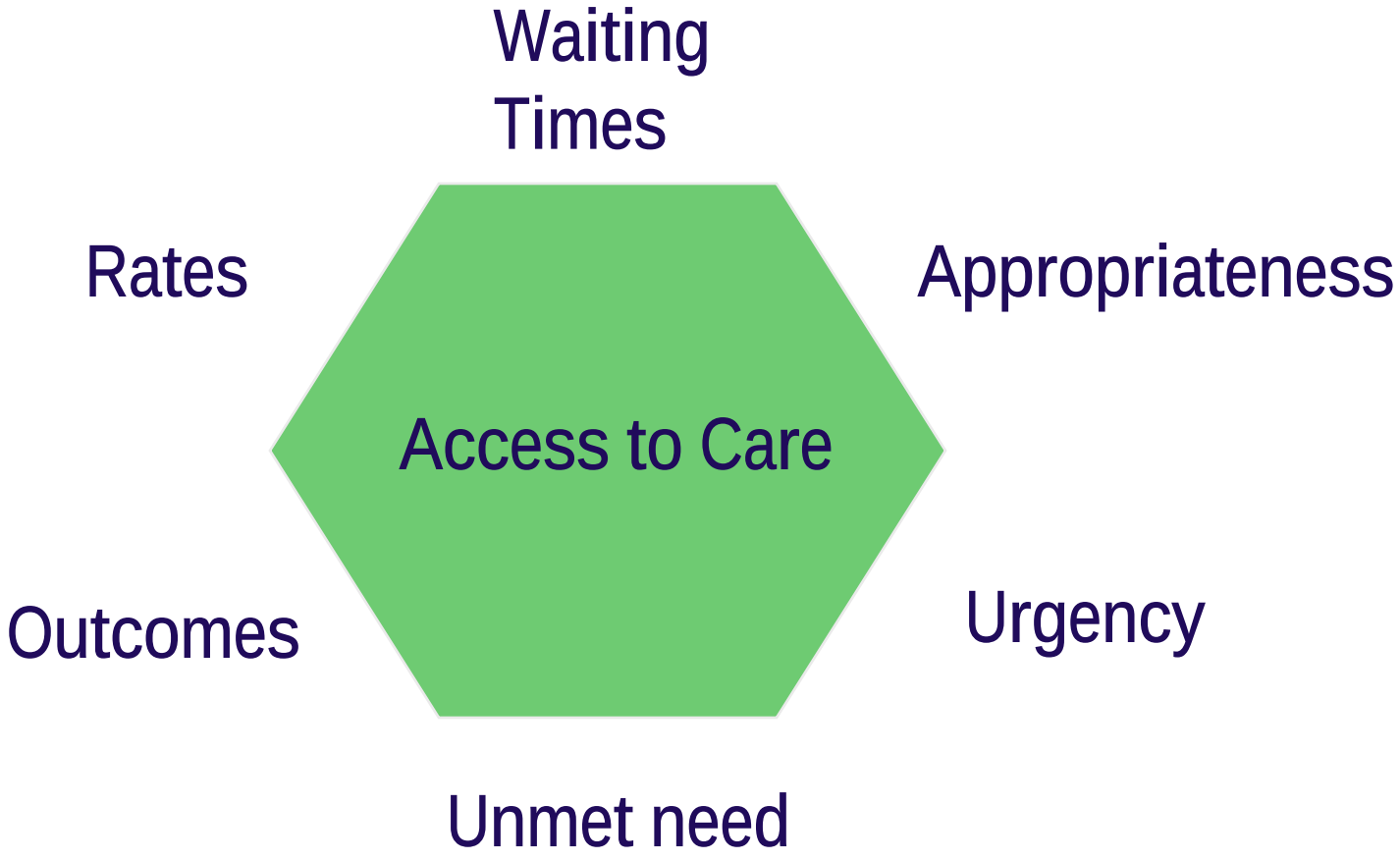
First Minister's Conference (Sept 2004)

- To develop, by December 2005, national 'evidence-based' benchmarks for medically acceptable waiting times for 5 priority clinical conditions
  - Cardiac Care
  - Cancer Care
  - Hip & Knee Surgery
  - CT/MRIs
  - Sight Restoration
- Benchmarks are to be developed by medical experts

Issues

- What should we call the benchmarks?
- Who should determine the benchmarks?
- What are the concerns of the stakeholders?
- What types of evidence should be used?
- What should be done?

Framework for ‘Access to Care’



What should national benchmarks be called?

- CCN: Recommended Maximum Waiting Times
- WCWL: Maximum Acceptable Wait Time
- Fraser Institute: Median Reasonable Waiting Time
- Saskatchewan: Target Wait Time
- England: Wait Time Guarantee

Who should decide national benchmarks?

- Government (federal/provincial)
- Clinicians
- Researchers
- Patients/Public

What are the advantages to setting benchmarks?

- Policy makers, managers, and providers will have clear goals to work towards
- Public confidence in system will improve if wait times decrease
- Development of waiting list registries will be stimulated

What are the concerns re: benchmarks?

- Political considerations
- Financial constraints
- Health Human Resources
- Care guarantees
- Legal liability
- Cannibalism
- Evidence

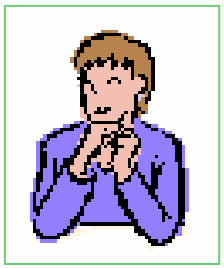
“Ideal” wait time benchmark

- Based on expert committee review and synthesis of high-quality scientific evidence.
- Reflects clinical urgency
- Measurable
- Achievable
- Modifiable
- Acceptable to government, providers, patients

Types of Scientific Evidence

1. Randomized controlled trial – Gold Standard
2. Cohort study – Clinical registry
3. Delphi panel – Hypothetical cases
4. Physician/Public Surveys
5. Expert Opinion
6. Anecdotal cases

Randomized Trials of Waiting Times



Patients with appropriate indication for surgery

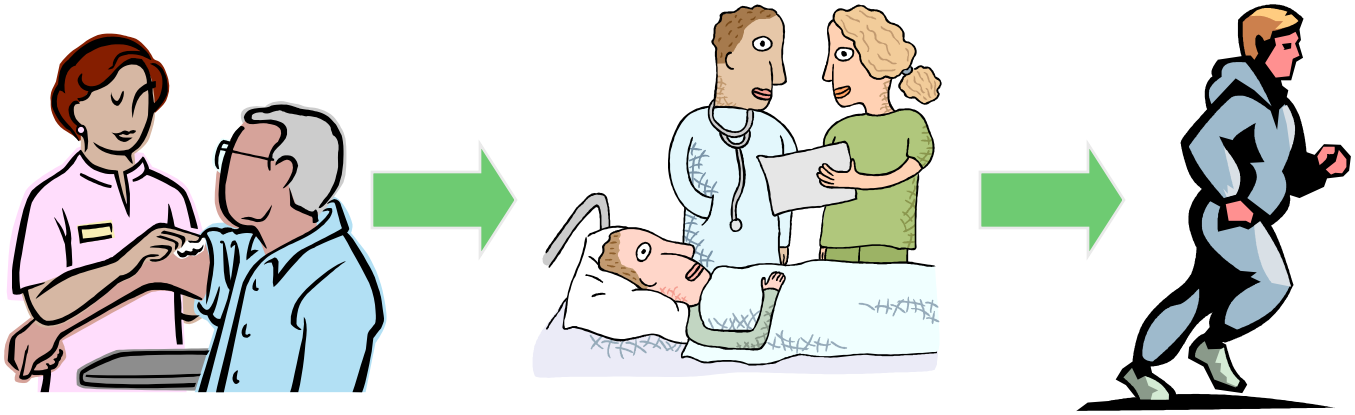
Expedited Care → Outcome

vs

Routine Care → Outcome

Cohort Studies

- Study patients with different waiting time intervals



Pre-operative assessment

Peri-operative outcome

Post-operative outcome

Delphi Panel Approach (CCN/ICES, WCWL)

- Establish Expert Panel – Clinicians and Researchers
- Review existing scientific literature on waiting times
- Create hypothetical clinical case scenarios for urgency assessment
- Convene meeting of panel members for ratings of clinical urgency (Delphi Panel process)

Delphi Panel Approach cont'd (CCN/ICES, WCWL)

- Analyze panel members ratings
- Create quantitative 'scoring' system (and refine) and develop waiting time benchmarks
- Pilot test resulting system for face validity and practicality
- Implement system and collect data
- Longer term – Validate urgency rating system and benchmarks with actual patient outcomes

Physician Surveys (Fraser Institute Survey)

- Median reasonable wait times
- Several years of data
- Poor response rate
- Results vary by province

Expert Opinion

- Expert committee reviews literature and provides recommendations
- Canadian Medical Association
- Various specialist societies

Summary

- Limited amount of high-quality “evidence”
- This is unlikely to change in the near future because of complex nature of the problem.
- All types of evidence should be considered in developing national benchmarks

Challenges involved in developing evidence-based waiting time benchmarks

- Few Canadian experts in waiting list research
  - Requires clinical expertise, scientific knowledge, methodologically difficult, long-term funding, highly ‘politicized’.
- Little high-quality waiting list research available from other countries
- Difficult to measure quality of life (“e.g. pain”-reliability, validity, gaming), which is the primary issue with most waiting lists

Additional challenges

- Patient prioritization tools cannot account for all factors affecting clinical urgency
  - e.g. Social factors, resource issues.
  - Clinicians will still have to rely on their own clinical judgment when treating heterogeneous patients.
- More useful as a systems monitoring tool
- Clinical indications for many procedures (e.g MRI scanning) changing rapidly.

What should be done?

- Choose initial national benchmarks using the best-available evidence and/or expert opinion.
- Clinicians should recommend the benchmarks
- Policy makers should set the targets within their province
- Focus on increasing the proportion of cases done within given benchmarks

What should be done?

- All provinces should develop clinical registries to capture wait list data
- Fund high-quality research: RCTs, cohort studies, recognizing that results may be years away

Conclusions

- Development of national benchmarks for waiting times is an important policy objective
- Nevertheless, there are significant challenges to be overcome
- Initial benchmarks should be set based upon the best-available data but long-term studies are needed to develop better ‘evidence-based’ benchmarks.
- Need to study related-issues (appropriateness, rates, unmet need, outcomes)