The Taming of the Queue IV: New Frontiers of Wait Time Measurement, Monitoring and Management

Conference Report

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Tom McIntosh and Patrick Fafard
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Introduction

Not many conferences attended mostly by researchers and policy-makers can boast having had the Prime Minister come for lunch. But Prime Minister Stephen Harper made a lunchtime appearance at the 4th annual Taming of the Queue conference in Ottawa on April 4, 2007 to announce, along with federal Minister of Health Tony Clement, agreements between the federal government and the 13 provinces and territories with regard to meeting specific wait time targets in exchange for targeted federal funds. Without a doubt, the announcement caused more than a ripple through the crowd of participants, many of whom had attended all or most of the previous Taming of the Queue conferences, as it served to highlight both the progress that has been made on the wait time issue and how much work still remains to be done.

The most recent iteration of the Taming of the Queue event marked something of a departure from past versions of the conference. Whereas TQ I-III focused mostly on the Canadian experience in terms of problem definition, tracking progress and sharing innovations, TQ IV had a far greater emphasis than its predecessors on the international experience with wait list management and some of the new challenges emerging in other countries in terms of managing service delivery across borders.

The day and a half event devoted most of its first full day to presentations and discussion of international developments in wait time monitoring, measurement and management in health care systems as diverse as those of Sweden, the United Kingdom, Australia and New Zealand. The presentations on the first day also addressed issues such as inter-jurisdictional patient mobility (which has a clear parallel with Canada's very decentralized service delivery systems), rationing of services, and dealing with wait times in a mixed public/private system. Each of these presentations was followed by a discussant from Canada charged with extracting the key lessons for Canada or paralleling the international experience with the Canadian one. The latter part of Day 1 and the half-day on Day 2 moved the focus to recent developments in Canada and, in particular, to identifying some of the yet under-researched and under-appreciated issues surrounding wait times in areas that have received far less media and government attention over the last number of years.

In the final analysis, a couple of key themes would emerge from the event which parallel the conclusions of past TQ conferences but also indicate an ability on the part of Canadians to speak more confidently about what is going on in Canada, what progress has been made and how Canada's challenges compare and contrast with those of other countries. Leadership – political, bureaucratic and from providers – was a key factor in the success stories related at the conference. The need to keep a watchful eye on the appropriateness of the services being provided given technological and other innovations was revisited time and again by presenters. The solutions were complex and involve a strong commitment to collaboration and knowledge exchange in order to properly conceptualize the problems and chart course(s) of action.

As Canada makes progress on the so-called "big five" areas of joint replacement, cardiac surgery, cancer care, advanced diagnostics and sight restoration, there was a clear need to keep an eye out for both "collateral damage" to the provision of other services and to take seriously the issue of wait times from the "storefront" of community care and the physician's office through the continuum of care to Canada's long-term care services. And, finally, as the presence of the Prime Minister made clear to all participants, the issue of wait time management is fraught with politics that lie, in the words of conference co-chair Tom Noseworthy, "around every corner."

What follows then are summaries of the presentations made to the Taming of the Queue IV conference that focus not only on the broader themes noted above, but also attempt to distil the key lessons that came from each specific line of analysis. The actual presentations themselves are also available on the Web site of Canadian Policy Research Networks (www.cprn.org) along with those from past conferences and past conference reports.

Day 1: Wednesday, April 4, 2007

1. Opening Comments and Welcome from the Co-Chairs

The conference was opened by co-chairs Cathy Séguin of Toronto's Hospital for Sick Children and Dr. Tom Noseworthy of the University of Calgary. Séguin noted that this year's conference had two very clear objectives:

1) To look at international development in reducing wait times, what can we learn from the successes of other countries, and how do their experiences relate to the Canadian context; and,
2) To look at what kind of improvement has happened in the Canadian context and how we can move beyond the "big five."

Séguin noted that we must always be cognizant of our own specific context around the wait times debate in this country. That context was marked by a couple of key events she described as "landmarks" – the 2004 First Minister's Accord that first enunciated the "big five" areas for wait time reduction, the recent Supreme Court ruling on Quebec's ban on private insurance and recent moves to create a pan-Canadian approach to wait time monitoring and management.

Bringing together both the international and Canadian experiences would demonstrate, Noseworthy noted, that not only can Canada learn from these experiences of others but that Canada would prove able to contribute its own knowledge and its own experiences to those other countries struggling to reduce wait times and better manage wait lists. And he further noted that simple solutions, like a parallel private system, would not necessarily have the effects proponents presume given that countries with such dual systems, some represented at the conference, still have real challenges when it comes to managing wait times.

2. Reducing Waits and Improving Access to Health Services: Learning from International Experiences

Presentation #1

Julia R.A. Taylor, *"No Delays Programme": Supporting the NHS achieve the 18 week pathway. Improving access for patients.*

The first initiative to address wait times in the British National Health Service (NHS) was begun in 1970, illustrating that this issue has been a concern (off and on) in the UK perhaps longer than in any other jurisdiction. Under the NHS Improvement Plan of 2004, the NHS made a commitment that by December 2008 no one in the UK would wait longer than 18 weeks from referral to hospital treatment.

As Julia Taylor (National Programme Director for NHS Institute for Innovation and Improvement) noted in the conference's first presentation, this was an ambitious target involving significant system change that has yet to be met. But at the same time, progress is being made and the Institute for Innovation and Improvement is a key player in helping the NHS reconceptualize its approach to large system change by involving the workforce as an active participant in that change.

Rather than focus on "wait list initiatives" per se, Taylor outlined an approach that focused on a fundamental reorganization of the way the system works and the way patients move across the continuum of care. In a sense, it comes down to treating the cause of the problem, not just the symptom of the wait list itself.

Thus, for Taylor, the focus should be on:

- The quality of the services provided;
- Managing bottlenecks within the system by optimizing current capacity;
- Planning for no (or minimal) queues through better capacity planning and reducing variations in supply and demand; and,
- Understanding the flow of patients through the system.

Delays in treatment are not the result of high volumes of patients seeking a specific treatment, but rather lie in the variability of demand and capacity and high utilization rates. In the short term, the focus needs to be on optimizing the current capacity within the system through reducing the number of steps in a patient's journey through the system, working on a first-come, first-served basis rather than batching patients and/or processes and pooling human resource capacity to maximize skill use for common activities or treatments.

In the longer term, the focus needs to be on planning for minimal or no queues by better measurement of demand and better planning for capacity and, most importantly, reducing the variation between supply and demand for services. A focus on reducing variation is not only about reducing wait times but also about improving patient safety, quality of care and controlling costs.

The Institute's "No Delays Programme" identified six elements that will make a big difference in how long patients wait:

- Planning ahead – along all stages of a patient's journey;
- Keeping the flow moving;
- Pooling similar work and sharing staff resources;
- Reducing elements in the journey that do not add value to patients;
- Seeing and treating patients on a first-in, first-out basis; and,
- Focusing on the whole of the patient's journey as well as on the providers in the team or work unit treating the patient.

According to Taylor, what is key to the successful improvements being made in the NHS is not just that wait times are going down but that they need to be going down as part of a "revolutionary" reconceptualization of the way the system can work. And key to that is the active participation of the workforce within the system as a catalyst for that change. It is not just the management of behaviour, but more akin to a "social movement" approach that relies on a bottom-up rather than a top-down process that begins with some fundamental reordering of the way providers approach and deliver care to patients.

Discussant's Comments and Q & A

Dr. Alan Hudson's (Ontario Access to Services and Wait Time Strategy) comments focused on drawing some parallels between that province's approach and the kind of approach outlined by Taylor. He noted:

- Canada's targets for wait time reduction (i.e. the big five) are rudimentary, though progress is being made and Ontario is moving toward measuring all surgical procedures in a more comprehensive manner;
- Ontario is focused on changing physician behaviour and having some success with the use of expert panels as leaders in this endeavour;
- Ontario has made quality improvement a prerequisite for funding wait time initiatives;
- There is still little discussion of the issue of "appropriateness" of both referrals and treatment given that thresholds for some procedures and services are continuing to fall and more and more patients are deemed "eligible" for specific services; and,
- There are still failings in our ability to report progress to the public in an effective manner that communicates change and improvement.

A question was asked about the role that the private provision of services played in the current situation in the NHS and whether that private investment accounted for the success of the wait time reductions. In response, Taylor noted that insofar as the patient continues to receive free care, the use of private sector providers for some services has had an impact on waiting times by increasing capacity.

Taylor's response and the questions from the floor that followed identified a couple of the key success factors that were crucial for the Canadian experience. First, leadership within the system was an essential component of making high quality processes into replicable best practices across the system. Second, successful strategies were those that understood the multi-factoral nature of the problem and dealt with changing processes, reducing variation, pooling skill mix, etc., simultaneously as part of a more holistic approach to the problem.

Presentation #2

Dr. Johan Calltorp, *Sweden's 0-7-90-90 Care Guarantee – Where Simplicity Meets Pragmatism?*

Dr. Calltorp, a professor of Health Policy and Management and the former Director of Health Services for the Western Health Services Region in Sweden, began his discussion of the Swedish experience with so-called "care guarantees" by outlining a series of structural changes to the Swedish health care system beginning in 1995. These included the merger of hospitals, the creation of larger health service regions and increased cooperation within the continuum of care and between county council borders.

Interestingly, Sweden's first care guarantee initiative (from 1992 to 1997) was deemed unsuccessful because it paid too much attention to the supply side of the equation without understanding the complex interplay of supply and demand that creates queues in publicly-financed systems that aim at population coverage, equity and cost control.

The current care guarantee initiative is aimed at providing:

- Same-day access to primary health care system (0);
- Visit to general practitioner within one week (7);
- Referral to specialist within three months (90);
- Completion of all medically indicated treatments within an additional three months (90); and,
- Failure to meet the guarantee allows patients to access care outside of the country at the system's expense.

Though the word used by the political actors in the system is "guarantees," Calltorp stressed that what is really being developed are "targets" for the system in terms of its ability to provide timely access. And, having learned from its first attempt to implement similar targets, the approach to these targets has been fundamentally different. In the first instance there is a recognition of the multi-faceted nature of wait times – that they are a result of the interplay of a variety of forces and that multiple policy levers need to be pulled simultaneously in order for the appropriate changes to be made in the system such that the targets can be met for the vast majority of patients.

The roll-out of the current targets began with a National Preparation Project that was designed to set the stage for the implementation of the targets. Involving teams of experts within each region and additional funds provided by the national government, each county council outlined its plans

for meeting targets and did so in a manner that built on past experience where the targets were not met and through sharing of best practices among the councils themselves.

One of the key challenges was the issue of defining "appropriateness." It was noted that there were some significant variations across medical practices as to when a decision to treat was taken. As well, there was a general tendency over time for decisions to treat to be taken with fewer or less severe indications of need or impairment. Thus, there was a concerted effort to begin to define prioritization criteria for specific interventions that could be standardized across the system.

These tools were supplemented by other tools that were designed to ameliorate some of the side effects of care guarantees for specific procedures, including the possibility that non-priority services could be neglected in order to meet the targets in priority areas and that any effort at setting targets and meeting them has to also be balanced with consideration of other resource allocation decisions that are taken at the administrative and political levels of the state. And communicating this to patient groups was itself an important component of rolling out the guarantees.

This comes down to the interplay between:

- The allocation of resources to the health system generally on the basis of need and relative to other allocation decisions;
- The allocation of those resources horizontally across different areas of health service delivery; and,
- The allocation of resources vertically within sectors of the health system on the basis of transparent prioritization tools that ensure those in most need are treated accordingly.

Thus what Calltorp described was a much more planned process underway with this iteration of care guarantees than was evident with the previous attempt. It is interesting to note that while Calltorp was cautious about the use of the word "guarantees" because of its highly political nature, there is some evidence that when implemented in a manner that recognizes the complexity of the system they are designed to serve, there is progress that can be demonstrated.

Discussant's Comments and Q & A

Discussant Sarah Kramer of Cancer Care Ontario noted that in the Canadian context it was no longer a question of whether the Canadian system was going to move toward guarantees/targets or not, but rather, how the system was going to address them.

There has been widespread acceptance of the need to "manage" wait lists in an active manner, but it leaves us with some difficult challenges that we are only beginning to face, including:

- How to move patients from one list (provider) to another when they may be reluctant to accept care from someone other than the provider they know; and,
- How to appropriately assist patients in navigating their continuum of care in an environment where the wait times are being actively managed.

Kramer noted that the focus in Ontario has, to date, been far too centred on "the decision to treat" rather than on the whole of the continuum of care. Patients needed not only the ability to make choices about their own care, but the knowledge to make the appropriate choices for their circumstances which itself requires a far greater democratization of knowledge as it relates to the transformation of clinical practice. In response, Calltorp noted that while this sharing of knowledge was indeed important, it was also fraught with challenges insofar as it threatens to fundamentally change the nature of the doctor-patient relationship and, as such, will be resisted by a number of actors in the system.

Questions from participants focused on a number of issues around the implementation of the new Swedish guarantee. It was noted that the failure of the first initiative in the 1990s made physicians initially quite sceptical of the new initiative when it was first proposed, but that the roll-out of the new initiative was designed precisely to overcome that scepticism. Asked whether there was any indication of a correlation between reduced wait times and population health outcomes, Calltorp noted that there was no such evidence and that given that the determinants of health were so complex and multi-faceted (and extended so far beyond access to health care services), it would be unlikely if such a direct correlation could ever be established.

Finally, it was asked whether the use of the word "guarantee" implied specific legal obligations which have been a strong concern within some quarters of the Canadian health policy community in this country's debate over care guarantees. Calltorp reiterated his concern with the word itself and recommended that it not be used to describe what are essentially targets, but further noted that where the target is not met, the patient can opt to travel out of country for service and this option is taken by about 10% of patients. Kramer also noted that in her view the use of the word "guarantee" in the political and media arenas was itself an indication of how a culture of consumerism has transformed the discussion of clinical outcomes within the system.

Presentation #3

Dr. Stephen Duckett, *Managing Wait Times in a Mixed Public-Private System – The Experience from Down Under*.

Stephen Duckett, Executive Director, Reform and Development Division of Queensland Health, began, like the previous presenters, by noting the very specific policy context that surrounds the wait time issue in Australia. The Australian health system is a primarily public system with a parallel private delivery system that is supported by public subsidy of private insurance premiums. But it is important to note that most elective surgery is performed in the private parallel system and there is a correlation between long waits in the public system and a larger presence of the private system whether one compares across states or medical specialty.

The presentation focused on the mix of policy and program initiatives that, collectively, can be said to constitute Australia's approach to wait list management. Each of these overall approaches had a series of initiatives.

First, the Australians focused on a series of initiatives aimed at increasing and improving capacity that included:

- Separation of elective from acute interventions and streaming within the elective category (75% of elective admissions stay less than one day and complex procedures requiring longer than five days account for between 5% and 10% of cases);
- Efficiency initiatives to change behaviour, including optimizing use of both human and physical resources (e.g. operating theatres);
- Outsourcing of some services in one-off "blitzes" through contracts with the private sector – though it was also noted that there are some longer term contracts with the private sector to deliver services to public sector patients;
- Redirection strategies that included the consolidation of lists and the creation of specialized high volume units for specialized services like cataracts and joint replacements; and,
- Development of clear guidelines for referrals, priority setting and timeliness expectations for both inpatients and outpatients.

Second, better provision of information was a key priority in the Australian approach, but as Duckett noted this has proved problematic in some cases. There is debate about the kind of information to provide consumers with (e.g. data on the experience of those waiting vs. the experience of those admitted from lists) and whether data should be provided at the physician level, at what level of specialty, etc. Different states have taken different approaches to the provision of public information which makes cross-state comparisons difficult. There was more success, however, in the development of systematic priority setting tools to assess the acuity of individual patient needs, though there is a perception that while individual "raters" may be consistent there is inconsistency among raters.

A third element of the Australian approach were initiatives aimed at prevention and diversion of hospital admissions through programs like:

- The Victorian Hospital Admission Reduction Program;
- A focus on "avoidable hospital admissions" in public reporting at the national, state and regional levels; and,
- Orthopaedic physiotherapy screening clinics that could divert some patients from surgery through access to physiotherapy to improve mobility and quality of life and possibly reduce progression to surgery for some patients.

Finally, there are programs offering both penalties for failure to meet targets and incentives for those institutions that do meet them. The State of Victoria has the longest tradition of effective use of these strategies, imposing severe penalties for failure to treat Category 1 patients (those in greatest need) within 30 days and providing bonus funding for institutions that meet service targets.

In conclusion, Duckett noted that Australia has made some significant progress on reducing wait times, but the problem was far from fixed. There were multiple initiatives working in tandem, but no "magic bullet" that could be said to have laid the issue to rest.

Discussant's Comments and Q & A

John McGurran, a health care consultant, noted that there were important lessons to be learned from the somewhat mixed experience that Australia has had with patient scoring systems. The very good work in this area of initiatives, like the Western Canada Wait List Project (WCWL), have given us a good base, but he had some concern about the resources such initiatives need (especially in terms of bureaucratic support required to sustain them). It was also important to think about the fact that the mixed system in Australia provided some alternatives for the delivery of care that do not currently exist in Canada, though such a parallel system may be emerging in at least some parts of the country. And finally, McGurran noted that the issue of consequences for not meeting targets (either in the form of penalties – or incentives for compliance) was something that the Canadian system needed to pay attention to as we move toward making the targets that have been developed into "guarantees" in the minds of both politicians and the public.

Conference co-chair Cathy Séguin also raised the question of whether one can claim that wait lists are being reduced when this is being accomplished by outsourcing to private sector institutions.

In response, Duckett reiterated the importance of prioritization tools, despite their limitations, as a vehicle for wait time reduction. The ideal situation, he said, would be to reduce wait times to the point where the categories themselves were irrelevant.

Presentation #4

Dr. Ray Naden, *Confronting Difficult Choices in Wait Time Management – The New Zealand Experience*.

According to Ray Naden of the New Zealand Ministry of Health, the key challenge for that country's wait time strategy was coming to terms with the recognition that not all patients' health care needs can be met given the fiscal capacity of the New Zealand state. Thus, it is inevitable that the system must choose to give priority to one patient over another, but how the system makes those decisions and how those decisions get both communicated to and accepted by the public are difficult challenges. But, like Canadians, Naden noted that New Zealanders have a very strong sense of entitlement when it comes to their access to publicly-funded health care services.

For its part, the public wants:

- Access to necessary care
- To have confidence in the publicly-funded system
- To be treated fairly
- To have access to good information about their options

Although there is no legal right to access health care in New Zealand, the Code of Patients' Rights recognizes that those referred for assessment or waiting for surgery are entitled to "reasonable care" and "reasonable information" about their condition and when they will be treated. And there is case law indicating that any prioritization system must be "fair, systematic, evidence-based and transparent."

Thus the decision to explicitly ration care in New Zealand imposes a strong ethical requirement for fair and equitable treatment insofar as prioritization tools ultimately indicate who receives services and who does not. That determination is made on the basis of:

- The degree of clinical need of the individual
- The degree of expected benefit of the service to the individual

The principles that govern access to publicly-funded elective services for New Zealanders are:

- Clarity – Patients know whether they will or will not receive a publicly-funded service
- Timeliness – Patients must be told of the decision on availability of a service in the public system within 10 days of the request and must receive the service within six months
- Fairness – The decision to treat or not is based on criteria that are transparent, consistent, systematic and publicly available

This has led New Zealand to make significant progress in the development of relatively sophisticated prioritization tools (with significant involvement of clinicians) that have been developed, implemented and refined over the last number of years. This has taken place in an environment where the reality of the process (i.e. that some people will be denied treatment in the public system) has been openly acknowledged to the public.

Thus, in terms of progress, Naden reported that:

- Priority assessment for each patient is now required to be entered into a national booking system
- The Medical Council and the Health and Disability Commission statements require physicians to prioritize well
- Incentives are in place to have all patients in an acceptable prioritization system by July 1, 2007
- Processes are being developed to evaluate and register acceptable systems

Naden admitted that the system implemented in New Zealand came about in the context of having to make difficult choices over who would and would not receive services in the publicly-funded system. The government chose to make those decisions explicitly in as fair and as transparent a manner as possible, given the constraints within that system. There remained real challenges about how to dedicate incremental new resources in the system to enhance one service over another. But these decisions, too, will need to be made within the same ethical framework that has guided policy choices to date.

Discussant's Comments and Q & A

University of Toronto law professor and head of the CIHR Institute of Health Services and Policy Research, Dr. Colleen Flood, focused her comments on Naden's presentation on ten key points for consideration:

- New Zealand does not have a wait time guarantee as does Sweden, Denmark or Norway – or even wait time targets such as in the UK;
- New Zealand's strategy is to manage demand so it matches capacity, instead of the other way around. This re-engineering of demand instead of supply has important consequences;
- One has to ask whether not putting people on a wait list solely because the system does not have sufficient resources merely creates a "wait list for the wait list" and obscures the number of people in need of care;
- Similarly, one needs to ask whether the ability to ration in this way in New Zealand depends on the existence of the private parallel system (which covers 37% of the population), giving those who do not make the wait list an alternative that does not exist in Canada;
- Given that New Zealand's specialists can work in both private and public sectors, there is a concern whether this affects the capacity of the public system insofar as specialists spend less than half their time in the public system;
- All of this raises questions for Canada in terms of its approach to redefining the basket of services offered in the public system and whether such moves would create private markets for some services and would this detrimentally affect the quality of Medicare;
- There were good lessons to be learned from New Zealand in terms of providing certainty for patients within the system and those waiting to enter the system; and,
- Process is very important and there must be venues to access for patients who are unhappy, rather than push them towards litigation and the courts.

Naden's response indicated that while it was true that New Zealand was tackling demand overtly, one should not ignore the presence of other elements that are part of the strategy, like improvements in productivity. In regard to the private system he noted that, while 37% of the population had private health insurance, this accounted for less than 10% of expenditure on hospital services. Naden said that permitting physicians to practise in both systems also allowed better access to specialist services for small and rural communities.

Presentation #5

Helena Legido-Quigley, *Inter-Jurisdictional Patient Mobility as a Solution to Excessive Waits – Panacea or Pandora's Box?*

The issue of sending patients for treatment to other jurisdictions because of excessive wait times is particularly relevant to the Canadian situation insofar as the issue of sending patients to other provinces has been one of the key issues in the discussions concerning the potential creation of Canadian care guarantees. But as pointed out by Ms. Legido-Quigley, a Research Fellow at the

London School of Hygiene and Tropical Medicine, the issue of inter-jurisdictional mobility in the European Union (EU) is fraught with a combination of legal, political and practical concerns.

The most recent data demonstrates that the reimbursement costs for cross-border health care amount to about E800 million, which in 2000/01 amounted to 0.1% and 0.2% of public health care spending in Europe. The ability of individuals to both seek and receive health services across the EU is supported by the universal European Health Insurance Card (E111) and by rulings of the European court.

According to the typology presented, there are a number of different categories of people who seek health care services in other jurisdictions and who have different experiences because of this situation:

1) Temporary visitors abroad (mostly those who become ill while travelling)
    a. In these cases there are clearly problems with providers being reluctant to accept the E111 cards, forcing patients to pay out of pocket and get reimbursed when they return home.
    b. There are also issues with capacity in those areas that have large seasonal fluctuations of tourists, making accessing services difficult in some situations.
2) Long-term residents retiring to other countries
    a. There are large numbers of northern Europeans settling in southern Europe, where traditions of care may be significantly different (e.g. the reliance on family members as care providers).
    b. Some long-term residents may also lose their right to access care in their home countries.
3) People living in border regions seeking cross-border care which is closer and more convenient than care in their home country.
4) People seeking treatment abroad that they perceive as either cheaper or of better quality.
5) People who travel for bio-ethical-legal reasons
    a. This can include travel to receive abortion services, fertility services and access to euthanasia.
6) People who travel to seek highly specialized services
    a. Can often include travel from small countries (e.g. Malta, Cyprus, Ireland) to larger centres where services are available.
    b. Also includes travel for very specialized services like heart and lung transplants.

European Union governments have experimented in recent years with financing travel to other EU member states as a means of relieving pressure on domestic wait lists. The United Kingdom, Denmark, Norway and the Republic of Ireland have all had limited initiatives where selected patients have been sent abroad for care that had been delayed at home. There is no data on patients who refuse cross-border care, but it is clear that how one perceives the quality of the

health system in the host country will affect a person's willingness to travel. Those who accepted cross-border care were generally positive about its quality but there were concerns about language barriers, about the ability to take family members with them and about the continuity of care and after-care.

Legido-Quigley noted a series of both opportunities and risks with institutionalized cross-border care. On the opportunity side, she noted:

- In border areas it can mean treatment closer to home and the more rational use of resources.
- For areas with low population densities it can create access to otherwise unavailable services.
- It can provide incentives to improve care through pressure to reduce wait times.
- It can reveal weaknesses in some systems and lead to sharing of best practices.

On the risk side of the equation, she noted:

- Patients travelling on their own initiative can alter priority-setting activities domestically and jeopardize the principle of equity.
- Patients unable to afford the cost of treatment abroad may have reduced access to care.
- Can put pressure on established organizational arrangements and can be very expensive for smaller countries.

In conclusion, it was noted that there remains a great deal that is not known about cross-border travel for care. But it was clear that there needed to be a much stronger legal and institutional framework for both facilitating and regulating cross-border access to care. This is a reality for the EU and one that must be adapted to in a manner that minimizes its ability to distort domestic health care policy for member states.

Discussant's Comments and Q & A

Dr. Peter Glynn, a private health care policy consultant with vast experience in the wait time issue in Canada (including as founding Chair of the Saskatchewan Surgical Care Network), noted, in the first instance, that this was the first presentation to focus specifically on the issue of patients and their perceptions of access to quality care. Outside of the core of services provided for under the Canada Health Act, there are variations across the provinces in terms of what is and is not covered by public insurance which, combined with perceptions of the quality of care in other provinces, will determine Canadians' willingness to move across borders to receive care. Thus it is important to take these perceptions into account when proposing change, as there are a number of factors that make Canadians' willingness to travel for care relatively low. Change will take leadership from inside the system and a very clear process for both collecting and analyzing the data around patient travel.

The question and answer session raised a number of issues for consideration. In order to refer patients to other jurisdictions, physicians need to have knowledge of wait times across the country, which is not something that can be assumed. Further, of concern to Canadians would be the perception that people travelling for care are, in effect, queue jumping. Legido-Quigley

noted that in the EU case, perceptions of queue jumping varied from country to country, with some countries more concerned about this issue than others. It was also noted that virtually all of the travel for care was for surgical procedures and not for other medical treatments.

3. The Canadian Experience – Looking Back, Looking Forward

The latter part of the first day of the conference began with the discussion of some of the specifics of the recent Canadian experience with wait time management.

Presentation # 6

Dr. Marie-Pascale Pomey, *Contextual and Local Success Factors in the Management of Wait Times for Scheduled Care*.

Dr. Pomey, both a physician and public health specialist currently at the Université de Montréal, reviewed a recent initiative she led to identify (both within the literature and through key informant interviews) the success factors in wait time management initiatives in Canada. The objective of the project was to synthesize the information from both the systematic literature review and the interviews in order to:

1) Identify the policy and organizational determinants associated with the management of wait times; and,
2) Advise policy-makers and health care managers on the best courses of action associated with the implementation of wait time management strategies.

The literature on wait time management was found to be mostly descriptive in nature with few empirical studies and focused mostly on outcomes of wait time strategies, with little attention paid to implementation or to the importance of contextual factors. Of over 5000 articles, 31 peer-reviewed articles describing organizational factors for the implementation of a WTM strategy were fully abstracted according to the four dimensions of the research initial conceptual framework.

The key informant interviews, involving 21 people in 17 interviews/focus groups across a broad spectrum of local and regional/provincial initiatives of different types, helped identify some similar success factors as in the literature.

The resulting analysis identified contextual factors that were important for successful wait time management (WTM) strategies. These factors are grouped under four dimensions:

1) Governance, including:
    a. Leadership by credible individuals and an independent structure
    b. Strong political and administrative support
    c. Accountability for hospitals
    d. Benchmarks for competition
    e. Inclusion in a national or regional strategy

2) Culture, including:
    a. Positive elements such as:
        i. Participatory processes
        ii. High quality public information
        iii. Culture of evaluation and communication inside the organization
        iv. Responsiveness to the culture of the physicians involved
    b. Negative elements such as:
        i. History of animosity among stakeholders
        ii. Culture of mistrust between the hospital/regional health authority and the ministry of health in the province
3) Tools, including:
    a. Existing provincial registry
    b. Provincial standards and guidelines
    c. Communications campaign (including a public Web site)
    d. The use of indicators, queueing theory and sophisticated modelling
4) Resources, including financial incentives

At the organizational level these same four broad dimensions were used to group the factors, but with different emphasis. Pomey described them in the following manner:

1) Governance, including
    a. Credible internal leadership (especially support from the CEO and senior executive level)
    b. Partnerships with other provincial organizations
2) Culture, relating to stakeholder perceptions, including:
    a. Positive factors
        i. Organizational culture of data collection/evaluation
        ii. Organizational culture of innovation
        iii. Strong team identification and reliance on non-punitive approach
    b. Negative factors
        i. Physician resistance
        ii. Differing sub-cultures within one organization
        iii. Heavy focus on costs
3) Tools, including:
    a. Clinical guidelines, evaluation tools and pathways
    b. Information technology

c. Training and support

d. Process for resource allocation

4) Resources, including:

   a. Positive factors:
      i. Seed money for the organization
      ii. Incentives at the local level
      iii. Dedicated human resources for data collection

   b. Negative factors:
      i. Insufficient funds
      ii. Shortages of human resources
      iii. Type of infrastructure and availability

The key lessons that were learned from the interviews were that:

1) Effective leadership inside an organization was crucial to successful implementation of WTM strategies:

2) Physicians had to be recognized as key players in the implementation and that their participation was crucial to overcoming both resistance to change and their tendency to protect their autonomy; and,

3) Money would not solve the problem but some initial investment of resources and the use of financial incentives were important to successful implementation.

In terms of recommendations, Pomey's research indicates that for top-down initiatives there must be local buy-in and that local initiatives need access to special funds from the top in order to be successful. Further, cultural factors (both positive and negative) should not be ignored as they can clearly influence successful implementation, and that higher-level decision-makers need to be cognizant of the organizational factors that can influence successful implementation. Finally, there is a need for ongoing substantive monitoring of implementation processes at the organizational level for all kinds of WTM strategies, whether local, regional, provincial or national.

Presentation #7 (Panel of Clinicians and Managers)

Dr. Lorne Bellan (Wait Time Alliance), Susan Scrivens (Vancouver Coastal Health) and Janice Skot (Royal Victoria Hospital), *Benchmarks, Targets and Guarantees: Perspectives on Meeting Expectations for Timely Health Care.*

The panel that made up the final session of the first day of the conference brought together the quite varied experiences of managers and clinicians who are charged, to different degrees, with the management of wait times at the coalface of the health care system.

Lorne Bellan's experience as co-chair of the Wait Time Alliance (WTA), as well as his past involvement in the Western Canada Waiting List Project, gives him first-hand experience in the development of both assessment tools and the setting of benchmarks for the health care system. The Wait Time Alliance brought together a vast array of clinical experience to help develop report cards on how well provinces were making progress on reducing wait times in the five priority areas of diagnostic imaging, joint replacement, cardiac care, cancer care and sight restoration.

The interim report cards issued by the WTA demonstrated significant progress in most areas of the "big five," but with some notable exceptions. For example, the targeted benchmarks in the area of cardiac care were aimed at only a small component of the overall wait time for cardiac patients seeking treatment such that the progress reported hides the very complex nature of wait times in this area. Further, the lack of clear benchmarks with regard to diagnostic imaging continues to be a problem for all jurisdictions despite this being one of the biggest wait time concerns for patients. Bellan expressed concern that the aging of the population could cast some doubt on the sustainability of the progress made in wait time reduction over the longer term unless faster progress was made and unless wait time strategies began to more explicitly plan for the increased demand that aging will likely place on the system.

Susan Scrivens works with the Regional Surgical Executive Council to implement the Surgical Access Strategy of the Vancouver Coastal Health Authority. The Strategy is a multi-faceted approach to wait time management that includes, among other elements, the BC surgical registry, the Authority's consistent operating room allocation model and wait time monitoring and reporting. The improvement made in the last few years, she argued, was helped by having both provincial and national benchmarks in place and by taking a multi-pronged approach to the issue. Some of the initiatives include the direct increase in capacity in some areas (e.g. joint replacement), creation of swing rooms to increase surgeons' capacity, smoothing the surgical bed flow, early assessment clinics and the creation of a regional Hip and Knee Pathway. In addition, the Authority undertook significant work in defining and measuring wait times and improving both the quality and timeliness of the data being collected. One of the biggest challenges for the Authority has been dealing with the tendency for some procedures to be given more emphasis because they are part of the "big five" (especially joint replacements and cataracts), thus compromising the ability to deliver other services. The Authority has been able to mitigate this by developing targets for all surgeries to monitor and prevent or correct for these effects.

Janice Skot, President and CEO of the Royal Victoria Hospital in Barrie, Ontario, spoke about confronting wait times from the perspective of a community hospital. While the hospital has achieved tremendous success in reducing wait times in a number of priority areas, it faces ongoing challenges which inhibit the hospital's ability to significantly improve wait times further, including:

- Limitations on the hospital's capacity
  - 50 days of over 100% occupancy in January and February of 2007
  - 58 of those days had people admitted to beds in hallways or overflow units
  - Over a 12 hour wait on average in the Emergency Room

- Questionable financial incentives for physicians based on complexity of wait time procedures.
- An accountability malaise whereby surgeons and program managers may not view themselves as accountable for fulfilling wait time contracts.
- The "snowbird" effect whereby residents who spend winter months south of the border want to schedule their procedures in the fall or spring only, thereby straining the hospital's capacity.
- Human resource limitations, in terms of the ability to increase permanent full-time staff, in the absence of multi-year contracts.

Skot believes that for the Wait Time Strategy to be successful, all pieces of the wait time puzzle must fit together, including: a robust information technology system for data collection and analysis; a provincial Human Resources strategy; sustainable multi-year funding; dialogue on the redistribution of funding/procedures; and the realignment of financial incentives for physicians.

Question and Answer Session

Skot was asked directly how department heads could be held accountable for wait time reduction targets. She replied by noting that the accountability lies in making clear to those who sign reduction target agreements that there are real and important consequences for failing to meet targets. Department heads have to know that the targets are real and that they have some ownership over what happens with those targets.

There was also a concern raised about the predicted increase in retirement of health care professionals and its potential impact on wait times. It was noted that while enrolments had increased in medical schools, there was an ongoing concern about who would train these new students after the wave of retirement reduced the number of faculty. Again, more sophisticated modelling and planning were needed to ensure that the system does not get caught short in its ability to adequately train new professionals.

Day 2: Thursday, April 5, 2007

4. The Canadian Experience – Looking Back, Looking Forward (continued)

Conference co-chair Tom Noseworthy opened the second day of the conference with a direct reference to the announcement made by the Prime Minister at the previous day's luncheon. "Something positive happened," he said, but also cautioned that the announcement could be seen in different lights. On the one hand, it should be acknowledged that getting the 14 jurisdictions in Canada to move in the same direction is very hard and any progress in that direction should be applauded. On the other hand, he noted that 13 different agreements for different wait time guarantees for different procedures could be seen as piecemeal and may not resonate with the public. Still, the very fact that the Prime Minister chose this event for the announcement is, he said, an indication of the kind of work the Taming of the Queue events have produced.

Presentation #8

Dr. Brian Postl**,** *Reducing Wait Times in Five "Priority" Areas: Challenges and Opportunities.*

Brian Postl, President and CEO of the Winnipeg Regional Health Authority gave an excellent start to the second day of the conference by providing a comprehensive overview of the progress made to date in managing and reducing wait times in Canada. Postl is very well placed to offer such an overview, having served as Federal Advisor on Wait Times from 2005 until 2006.

He began by emphasizing that there has been considerable progress in managing wait times in Canada. But while we have a much better understanding of the reasons why patients wait for care, what matters is of course results – reducing wait times. We also must contend with the fact that there are two quite different perceptions of the problem. For the general public, any wait for care is understood as a negative thing that leads to anxiety for patients and their families. In marked contrast, most people working in the health care system perceive at least some waiting as an inevitable part of the system.

What is of concern are excessive as opposed to reasonable wait times, assuming we can agree on what constitutes an excessive wait. Some of the factors that contribute to excessive waits include changing demographics – care providers are getting older and are changing their practice patterns; changing expectations on the part of both patients and providers – we are increasingly impatient about waiting for care; and an overall decline in the availability of both equipment and especially health human resources.

Postl emphasized that the discussion of wait times is clouded by a continuing lack of consistency in what we are measuring. For example, because we have many different health care systems in Canada, we still do not all agree on when the clock should start when measuring the time patients wait for care. While we often measure waiting with reference to specialists, some argue it should start earlier, from the referral by the family practitioner.

He then provided a useful short history of the debate over health sector wait times in Canada and some of the key dates from a pan-Canadian perspective including the 1998 report, *From Chaos to Order: Making Sense of Waiting Lists in Canada*; the health care renewal agenda driven by First Ministers and animated by the Romanow and Kirby reports; successive *Taming of the Queue* conferences; the federal government's 10-year plan to strengthen health care announced in 2004; his own report in July 2006; through to the wait times guarantee introduced by the current Conservative Government.

Postl noted that part of the 10-year plan was not only an allocation of $5.5B dollars for health care but also a commitment to set indicators and establish priority benchmarks for the "big five" priority areas: cancer, heart, diagnostic imaging, joint replacement and sight restoration. Achieving a consensus on how to define key benchmarks was the result of intensive and sometimes difficult deliberations facilitated, to some extent, by the Federal Advisor on Wait Times. The results are positive overall and the Canadian Institute of Health Information (CIHI) indicates that reporting on wait times has improved (in some provinces using publicly-accessible Web sites). Four provinces (Nova Scotia, Ontario, Manitoba and Alberta) have begun to report on all five priority areas, allowing some comparability, although there remain variations in the methodology used by different provinces to measure and report on wait times for health care.

Postl emphasized the importance of being clear about what is being compared with what so that we know to what extent the data are comparable. He also emphasized the critical importance of the frequency of reporting – if reports are not issued in a timely way it is difficult for anyone to develop a good picture of the flow of patients through the system. Conversely, if reports are issued too often, there will inevitably be relatively minor "bumps and lumps" in the data. He also emphasized the fact that most wait times for health care services in Canada are measured retrospectively, which is more accurate but assumes that the immediate future will be the same as the immediate past, which is not always the case by any means.

Have things improved? Are we getting better at defining, measuring and managing waiting for health care? Postl argues there can be no clear cut answer to this question. Wait times are going down, there are increased volumes of surgery done in most provinces, and we know more about how to manage wait times. He also offered quick summaries of the progress to date in most provinces. Conversely, it remains very difficult to compare one Canadian jurisdiction with another when it comes to health care wait times. As Postl put it, "we can compare to ourselves over time, to targets, but not to each other." Moreover, the Canadian Medical Protective Association (CMPA) has issued an information letter to physicians flagging the possibility of medico-legal considerations associated with wait times guarantees.

Looking to the future, Postl emphasized the role of physicians as critical agents for change in the system, often acting as leaders and champions of wait time reporting initiatives. He also noted that training is required in the area of wait times management and briefly described the initiatives of the Canadian Health Services Research Foundation and the Canadian Medical Association in this area. In closing, he called on health care providers to avoid finding fault and instead to join together to address wait times in collaborative and complementary ways.

Question and Answer Session

Following the presentation, in his responses to questions and comments from participants, Dr. Postl noted that process improvements that reduce wait times for patients and their families will continue, but in the absence of sufficient and continuing targeted government funding, the pace of change will be slow. He also reiterated the key role of physicians in the management of wait times and the fact that they need to take responsibility to change the dysfunctional management culture that contributes to unnecessary wait times. In closing, and in response to a question about the shortages of specialists, he noted that shortages would appear to go in cycles and that anaesthesia is currently part of the shortage cycle.

5. Beyond the "Big Five" – Improving Access and Reducing Wait Times in Other Key Areas

Presentation #9

Dr. John Maxted**,** *Wait Times in Primary Care* and Mary-Lynn Watson**,** *Emergency Access and Wait Times.*

With the overview provided by Dr. Postl as a backdrop, the conference then moved on to begin consideration of how to improve access and reduce wait times in areas beyond the so-called "big five" identified by First Ministers. Thus, the second presentation of the second day of the conference was by John Maxted, Associate Executive Director, Health and Public Policy, of the College of Family Physicians of Canada (CFPC). His key messages were that waiting for access to a family physician and primary care is a critical part of the wait times challenge in Canada and that defining and measuring these wait times is an immediate but very complex challenge.

Dr. Maxted began by describing the 2005 CFPC Position Statement on wait times that focused on five priority areas. The Statement emphasized first, that all Canadians need an opportunity to have a family doctor and gain access to the continuum of care; second, that there need to be pan-Canadian wait time benchmarks and targets, and that provincial and territorial governments have a responsibility to meet them; and third, that measurement is key, including the development of standardized criteria that define when patients are eligible to be put on a given wait list. The fourth core element of the 2005 Position Statement was a reiteration of the importance of a single-payer, publicly-funded health system for medically necessary services but that public funds could and should be used to deliver primary care in ways that go well beyond what patients might be used to (i.e. primary health care reform). The final element of the 2005 Statement was the critical importance of communications to patients about what constitutes an acceptable wait and on ongoing progress on reducing waiting times for care.

Maxted reported the results of some public opinion research done for the CFPC which suggests that approximately 17% of Canadians are without a family physician; that of those who did visit a family doctor, about 45% were referred to a specialist in the previous year, cardiology and orthopaedics being two of the most frequently accessed consulting services; and that approximately one in four Canadians feels that waiting times are too long. He also reported on a CFPC-sponsored poll of family physicians which showed that one in two family doctors felt that

waiting times were too long and that the top five areas with which they appeared to be having the greatest difficulty in referral were: orthopaedics, neurology, psychiatry, gastroenterology, and dermatology.

His presentation then moved to the challenge of defining what constitutes a wait for primary care. His presentation was based on a discussion paper released by the CFPC in October 2006 which emphasized that, from a patient's point of view, waiting begins from the moment that they experience symptoms or problems and well before they first come in contact with the formal health care system. He contrasted this with our current discussions of wait times that focus on the later steps, beginning with the referral to a specialist.

Drawing from the discussion paper, Dr. Maxted then described the challenges associated with defining wait times in primary care and developing the associated benchmarks and targets. He noted that there is a lack of empirical research evidence that would facilitate the development of guidelines for access to primary care. What is clear is that defining wait times for primary care will be challenging. He offered the common scenario where patients are exhibiting symptoms of multiple possible medical conditions. For example, how should we measure the wait time for patients who think they need a hip replacement? Should the wait start from the time the patient believes their pain started, from the point of initial assessment, or the point of a more definitive diagnosis? Similarly, how should wait times be defined for patients who present with multiple health problems, some urgent, some chronic, and some elective?

Dr. Maxted also pointed to issues of appropriateness, professional responsibility and the continuing critical importance of clinical judgement. Appropriateness here refers to questions like when should a patient be placed on a wait list; which diagnostic criteria are to be used; and when should a patient come off a list. Professional responsibility in this context means the responsibility of physicians and primary care teams to manage patient expectations, help patients secure a spot on wait lists, track the progress of patients, and ensure that access to care is based on urgency.

Dr. Maxted ended his presentation by describing the *CFPC-CMA Primary Care Wait Time Partnership* which has a mandate to explore the complex issues of wait times for primary care and develop evidence-based benchmarks for timely access to primary care.

When we think of wait times in health care we most often think of waiting for surgery or diagnostic services. In fact, for many Canadians the biggest waits in health care are found in the Emergency Department (ED). Thus, it was appropriate that Mary-Lynn Watson, President of the Canadian Association of Emergency Physicians (CAEP), provided an overview of how to define wait times in emergency departments, reviewed some of the causes and offered some observations on how to address excessive waits in emergency rooms.

In her presentation, Dr. Watson described some of the things that happen when emergency departments are overcrowded. Not only do ambulatory patients and their friends and families wait, she noted that often paramedics are unable to transfer patients to Emergency Department staff in a timely manner or must divert them to another hospital altogether. Similarly, other referring hospitals, especially in rural areas, are unable to transfer patients requiring a higher

level of care because urban receiving facilities are full. The effects of ED overcrowding are many and include putting public safety at risk, the loss of privacy and dignity of individual patients, increased medical errors, and negative effects on the teaching mission of hospitals.

Dr. Watson presented data that suggest that emergency departments are overcrowded because hospitals more generally are overcrowded. The absolute number of beds has declined at the same time as the number of seniors who are more frequent users of hospital services is increasing. Canadian hospitals frequently operate at unsustainable occupancy rates of 90% (with some operating at over 100% of capacity) which has serious effects on the operation of emergency departments. It is very hard to provide timely and appropriate care. Moreover, this problem is by no means unique to Canada. For example, ED overcrowding is a well-established problem in the United Kingdom and in New Zealand.

The problem of overcrowding in emergency departments can be further broken down by considering issues of input (i.e. who comes to the emergency department), throughput (i.e. how patients are managed once they get there) and output (i.e. what can and should happen to patients when they are ready to leave the emergency department). With respect to input, the problem is not one of low-acuity patients presenting at the ER. Rather, the problem is one of moving higher-acuity patients into the hospital (i.e. output). In fact, once the decision is made to admit patients to the hospital, they may remain in the emergency department for unacceptably long periods of time waiting for an inpatient bed. In other words, patients are admitted but remain in the emergency department in a virtual bed. The average wait for these patients is significantly longer.

Therefore, according to Dr. Watson, the solution to the problem of overcrowding in ERs is strongly linked to hospital outflow and discharge planning – how and when patients are moved from the hospital to home and, perhaps most importantly, to long-term care given that "alternate level of care" patients account for up to 20% of acute hospital care beds. More specifically, Dr. Watson suggested that the solution to overcrowding in ERs will require a multi-faceted response that includes the implementation of overcapacity protocols; the setting of national benchmarks for total emergency department length of stay; and increasing bed capacity and optimizing the use of existing beds.

The CAEP has developed a set of benchmarks for how long patients should remain in the emergency room with different benchmarks for differing levels of acuity. These were released in February 2007 as part of a broader CAEP position statement on emergency department overcrowding.

Question and Answer Session

In response to both presentations, a comment from the floor suggested that in the United Kingdom, serious efforts have been made to reduce inappropriate elective admissions to hospitals. As for primary care, there is a mix of skills with many different practitioners who now provide a wider range of care. This has gone some way to addressing shortages and in the UK it is estimated that all residents have access to a family doctor.

Another comment from the floor emphasized that in Canada, there is a challenging lack of human resources across the country. There is a shortage of both family physicians as well as many other health care providers. When these shortages are addressed appropriately, we will be able to address the issue of wait times for primary care.

There were several questions from the floor in response to the two presentations. One person raised issues of drug safety and how to deal with the fact that adverse reactions to pharmaceuticals are the cause of anywhere from 20% to 25% of visits to the emergency department. Another person asked about how we will respond to the pattern where some physicians are referring many patients to emergency rooms. A third person noted the importance of appropriate incentives, including blended payment arrangements for physicians, in the creation of family health teams and asked simply, where do we start?

In response, the panellists stressed that in building family health teams there is a need for all members of the team to become comfortable with new relationships and pay more attention to the referral process. In primary care there is enough work for everyone and funding is but one part of the solution although an important one given that significant pay differences make it more difficult to attract new physicians graduating from medical school to family medicine.

The final question from the floor for this session pointed to the need for national strategies for disease prevention if we are to deal with the tsunami of the shortage of health care professionals. The response from the panel was to emphasize that prevention is an extremely important part of primary care.

Presentation #10

Dr. Patrick J. McGrath**,** *Taming the Queue: Mental Health Treatments for Children* and Dr. James Wright, *Pediatric Surgical Care*.

Over the last ten years or so, mental health has come out from the shadows and is increasingly recognized for what it is: one of the most significant health challenges we collectively face and one which we have done relatively little to address. Thus, a comprehensive account of wait times in Canada must include a discussion of mental illness and an assessment of who waits for what, for how long, and with what consequences. As a step in this direction Patrick McGrath, from the Centre for Research in Family Health at the IWK Health Centre in Halifax, Nova Scotia, presented an overview of their efforts to begin to address waiting times for mental health treatments for children.

According to Professor McGrath, conservative estimates are that 15% of Canadian children have a diagnosable mental health disorder and work by the Senate Social Affairs Committee suggests that as many as 1.2 million young Canadians live with mental health disorders. However, the work of this same committee suggests that the health care system is not addressing the needs of these children. The fragmentation of the health and social service delivery systems, the shortage of mental health professionals, and the reliance on a provider-driven model (as opposed to a model driven by patient need), mean that children's mental health services are woefully

inadequate. Immediate and early interventions are often impossible even if this is essential to effectively treat children's mental illness.

Effective, evidence-based, cognitive-behavioural therapy combined with medico-pharmaceutical interventions are available. Unfortunately, effective treatments are often not used. Professor McGrath presented data that suggest that over 80% of children with diagnosable mental health disorders are not receiving care. In the case of children's mental health, the issue is not only or even primarily that waiting lists are too long but rather that the existing waiting lists are fragmented, chaotic and provider-focused, and long waits and social stigma mean that many children who have treatable mental illness are not even on wait lists for service.

Changing the system to increase the availability of children's mental health services is challenging because the costs of non-action are borne by other systems (i.e. criminal justice; social services). Moreover, families and those who would refer children feel a profound sense of hopelessness given the very long waiting times for care. Family physicians, for example, tend not to refer, unless the child poses an immediate threat to himself or to others. And, of course, there is the ever present social stigma attached to mental illness. Like other parts of the health care system, system change in children's mental health is also hampered by an acute shortage of appropriately trained health professionals. However, unlike other parts of the system that have begun to change the ways in which they deliver care, children's mental health care is still based on a craft model which emphasizes the expertise of individual health professionals; existing protocols for treatment are often not used; and, independent clinical judgement reigns even while it has been tempered in other parts of the health system.

While the recently announced Mental Health Commission is a modest start, Professor McGrath emphasized that much more needs to be done. Thus, while the Canadian Psychiatric Association has released benchmarks for access to mental health services, we have no data on the extent to which these benchmarks are being met.

In his presentation, Professor McGrath made the case for a more industrial model for the delivery of children's mental health services; one that uses evidence to develop the system; achieves higher efficiency by raising the volumes of services that are offered by individual providers or provider groups; and emphasizes stepped care reserving highly-trained craftspeople (e.g. psychiatrists) for only the most complex cases. This set the stage for Professor McGrath to end his presentation by describing innovations made in the delivery of mental health services for children in Nova Scotia, where a program of evidence-based mental health services (Family Help: www.bringinghealthhome.com) is delivered by telephone using "coaches" who are hired on the basis of being bright, capable and personable, with excellent communications and problem-solving skills. The use of these coaches, along with computer-based mental health treatment modules, has enabled families to be much more active in the care of children with mental health disorders. This approach has increased patient compliance, reduced the number of patients who drop out of care, and as preliminary evidence suggests, has reduced waiting times for children and their families for mental health services.

In Canada, acute and surgical care for children is often delivered by specialized hospitals in large Canadian cities. Like regular hospitals, they face a common problem of managing wait times but with children there is the added dimension of the time constraints imposed by childhood growth and development.

Dr. James Wright, Surgeon-in-Chief and Chief of Perioperative Services at the Hospital for Sick Children, reported on a "pan-Canadian" approach to addressing surgical wait times for children and youth in Canada, an initiative that builds on earlier work in British Columbia and by the Ontario Paediatric Surgical Wait Times project.

Dr. Wright began his presentation with a review of the Ontario project, the process used to develop wait time benchmarks, and the consensus reached on an appropriate wait time for different disorders requiring surgical intervention. Interestingly, the paediatric strategy measures wait times both from the moment of referral and the wait for surgery (in contrast to the usual approach for adults, which measures only the surgical waits from the point that surgery becomes the chosen course of action).

In February 2006, the surgical chiefs and senior administrators of 16 specialized children's hospitals met and agreed to develop a pan-Canadian system to measure surgical wait times for Canada's children and to focus on addressing surgical waits in one or more of six key areas. In January 2007, a pilot for paediatric surgical wait times was announced with funding from the Government of Canada and the overall goal is to reproduce what has been done in Ontario on a Canada-wide basis.

Question and Answer Session

During the question and answer session Dr. Wright was asked about the contrast between wait time guarantees for services in Quebec compared with the rest of the country. In his reply, Dr. Wright drew the distinction between an access target, which is the focus on the pilot project for paediatric surgery, and wait time guarantees which are province-specific. A focus on access targets allowed for a more consensual approach and diversity among provinces given that on the management side (e.g. managing and coordinating access to surgery on a province-wide basis), several other provinces are ahead of Ontario. In response to a question about the role of provincial governments in the development and roll-out of the national paediatric surgery pilot, Dr. Wright conceded that the January 2007 announcement did take several provinces by surprise.

Additional comments from the floor in response to the two presentations emphasized the need to look beyond wait times for surgery and other health care services and reflect on the broader spectrum of health and how services are delivered. For example, in Alberta, 85% of physiotherapists work in private practice. Another participant observed that technological change means that the way in which surgical and other services are delivered can and does change as new technologies become available. The presentation on children's mental health highlighted the role of telephone consultations, and the dramatic change in the way cataract surgery is done is another example.

6. Closing Comments and Key Messages

In their closing comments, the conference co-chairs re-emphasized the positive messages that were heard throughout the conference that real progress was being made in terms of measuring, monitoring, managing and, ultimately, reducing wait times in different parts of the system in different parts of the country. But there also remained some very hard work left to be done. Indeed the final sessions of the conference, in going beyond the "big five," in some ways returned the conference to where it had begun with the first Taming of the Queue – to areas where the work is only just beginning. The advantage of course is that work on reducing wait times for primary care, mental health and children's services will be greatly enhanced by the hard work already done in those areas that have benefited from so much research and political attention in recent years.

There were a number of key messages that ran throughout the conference and made their importance known in different contexts and in different ways:

1) Successful solutions require action on multiple fronts, for they are as complex as the wait time problem itself.

2) Collaboration, information sharing and learning from the experience of others are the keys to adapting successful wait time strategies to different contexts and environments.

3) There are health human resource issues always in the background and wait times cannot be reduced without due consideration given to the staffing needs of the system and to insuring the quality of care.

4) Priorities for action are important, but we must always be aware of the potential for collateral damage if too much attention is given to just those issues deemed to be priorities.

5) Attention needs to be paid to the wait times issues that exist from, in Noseworthy's phrase, "the storefront to the long-term care facility" – across the entire continuum of care.

6) Regardless of the research and the policy analysis that is done, we must always recognize that "politics are around every corner" in this debate and we must be mindful of how what we do plays out and influences the very real political debate around wait times.

Finally, it is clear that the success stories related over the course of the two days of the conference also very much reinforced an idea that has been central to the work on wait times since the issue first began to receive attention from researchers and politicians. Successful wait time strategies require champions willing to take on leadership roles and persevere in the face of sometimes strong opposition. Champions are required within the bureaucracy to sustain commitments to build new systems for monitoring and managing lists within the professions (especially within the medical profession), to break down resistance to change and to inculcate a new culture inside health care institutions and within governments, in order to ensure that there are adequate resources to both begin and carry through with the transformations required.

Appendix 1. Final Conference Agenda

The Taming of the Queue IV – New Frontiers of Wait Time Measurement, Monitoring and Management
April 4-5, 2007, Marriott Hotel – Ottawa, ON, *Victoria Ballroom*

Wednesday, April 4

8:00-8:30 am Registration and Continental Breakfast

8:30-8:45 am Welcome
Tom Noseworthy and Cathy Séguin

Reducing Waits and Improving Access to Health Services – Learning from International Experiences

8:45-9:45 am Managing change in large systems – achieving the 18-week wait
- Julia Taylor, NHS Institute for Innovation and Improvement, UK
- Canadian discussant: Alan Hudson, Ontario Access to Services and Wait Time Strategy

9:45-10:45 am Sweden's 0-7-90-90 Care Guarantee – Where Simplicity Meets Pragmatism?
- Johan Calltorp, Western Health Services Region, Sweden
- Canadian discussant: Sarah Kramer, Cancer Care Ontario

10:45-11:00 am Break

11:00 am-Noon Managing Wait Times in a Mixed Public-Private System – The Experience from Down Under
- Stephen Duckett, Queensland Health, Australia
- Canadian discussant: John McGurran, John McGurran Resources Ltd.

Noon-1:30 pm Lunch – Cartier Room
Keynote Speaker
- The Right Honourable Stephen Harper
  Prime Minister of Canada
  Also attending: The Honourable Tony Clement, Minister of Health, Canada

1:30-2:30 pm Confronting Difficult Choices in Wait Time Management – The New Zealand Experience
- Ray Naden, Ministry of Health, New Zealand
- Canadian discussant: Colleen Flood, CIHR Institute for Health Services and Policy Research

2:30-3:30 pm Inter-Jurisdictional Patient Mobility as a Solution to Excessive Waits – Panacea or Pandora's Box?
- Helena Legido-Quigley, London School of Hygiene and Tropical Medicine, UK
- Canadian discussant: Peter Glynn, PG Consulting & Saskatchewan Diagnostic Imaging Network

3:30-3:45 pm Break

The Canadian Experience – Looking Back, Looking Forward

3:45-4:15 pm Contextual and Local Success Factors in the Management of Wait Times for Scheduled Care
- Marie-Pascale Pomey, Université de Montréal

4:15-5:15 pm Panel of clinicians and managers: Benchmarks, Targets, and Guarantees – Perspectives on Meeting Expectations for Timely Health Care
- Lorne Bellan, Wait Time Alliance
- Susan Scrivens, Vancouver Coastal Health
- Janice Skot, Royal Victoria Hospital

5:45 pm Evening Reception – Victoria Gallery

Thursday, April 5

8:00-8:30 am Registration and Continental Breakfast

The Canadian Experience – Looking Back, Looking Forward (continued)

8:30-9:30 am Reducing Wait Times in Five "Priority" Areas – Challenges and Opportunities
- Brian Postl, Winnipeg Regional Health Authority and former Federal Advisor on Wait Times

9:30-10:30 am Beyond the "Big Five" – Improving Access and Reducing Wait Times in Other Key Areas
- *Primary care:* John Maxted, College of Family Physicians of Canada
- *Hospital emergency care:* Mary-Lynn Watson, Canadian Association of Emergency Physicians

10:30-10:45 am Break

10:45-11:45 am Beyond the "Big Five" – Improving Access and Reducing Wait Times in Other Key Areas (continued)
- *Mental health services:* Patrick McGrath, IWK Health Centre
- *Paediatric surgical care:* James Wright, Hospital for Sick Children

11:45 am-Noon Closing Comments
- Tom Noseworthy and Cathy Séguin

Noon-1:00 pm Lunch – Cartier Room

Adjournment

Appendix 2. List of Participants

Mr. Owen Adams	Canadian Medical Association	Ottawa, ON
Dr. Jonathan Agnew	British Columbia Medical Association	Vancouver, BC
Ms. Tory Atwood	McGill University Health Centre	Montréal (Québec)
Dr. Tom Bailey	The College of Family Physicians of Canada	Mississauga, ON
Mrs. Valarie Bakowski	Ministry of Health	Victoria, BC
Ms. Meena Ballantyne	Health Canada	Ottawa, ON
Mr. Clay Barber	Interior Health Authority	Kelowna, BC
Ms. Sue Beardall	Health Canada	Ottawa, ON
Mrs. Kathy Bell	New Brunswick Department of Health and Wellness	Fredericton, NB
Dr. Lorne Bellan	Wait Time Alliance	Winnipeg, MB
M^{me} Diane Bérubé	Centre hospitalier universitaire de Québec (CHUQ)	Québec (Québec)
Dr. Eric Bohm	Manitoba Orthopaedic Waiting List Reduction Steering Committee	Winnipeg, MB
Ms. Rosemary Boyd	Department of Health and Community Services – Government of Newfoundland	St. John's, NL
Dr. Neil Branch	New Brunswick Surgical Care Network	Bathurst, NB
Mr. Glenn Brimacombe	Association of Canadian Academic Healthcare Organizations	Ottawa, ON
Ms. Judy Budgell	Central Health	Grand Falls-Windsor, NL
Dr. Johan Calltorp	Western Health Services Region	Stockholm, Sweden
Mrs. Lori Chartier	Health Quality Council	Saskatoon, SK
The Honourable Tony Clement	Health Canada	Ottawa, ON
Mr. Paul-Émile Cloutier	Canadian Medical Association	Ottawa, ON
Ms. Élise Comtois	Canadian Health Services Research Foundation	Ottawa, ON
Mrs. Gwen Cook	Restigouche Health Authority	Campbellton, NB
Mrs. Janet Cooper	Canadian Pharmacists Association	Ottawa, ON
Ms. Lise Daigle	New Brunswick Department of Health and Wellness	Fredericton, NB
Ms. Cynthia Davis	Western Health	Corner Brook, NL

Mr. Kurt Davis	Canadian Society for Medical Laboratory Science	Hamilton, ON
Mrs. Trina Decker	Labrador Grenfell Health Authority	St. Anthony, NL
Ms. Denise Desautels	Canadian Healthcare Association	Ottawa, ON
Mrs. Mariana Diacu	British Columbia Ministry of Health	Victoria, BC
Ms. Suzanne Dionne	Champlain Local Health Integration Network	Ottawa, ON
Mr. Glen Doucet	Canadian Medical Association	Ottawa, ON
Mrs. Madeleine Drew	University of Ottawa	Ottawa, ON
Dr. Stephen Duckett	Queensland Health	Brisbane, Australia
Dr. David Elliott	Nova Scotia Department of Health	Halifax, NS
Mr. Nadeem Esmail	The Fraser Institute	Calgary, AB
Mr. Patrick Fafard	Canadian Policy Research Networks	Ottawa, ON
Mr. James Fahey	Champlain Local Health Integration Network	Ottawa, ON
Ms. Melissa Farrell	Ministry of Health and Long-Term Care	Toronto, ON
Dr. Della Faulkner	Canadian Nurses Association	Ottawa, ON
Mr. Frank Fedyk	Health Canada	Ottawa, ON
Dr. Colleen Flood	CIHR – Institute of Health Services and Policy Research	Toronto, ON
Ms. Catherine Fooks	The Change Foundation	Toronto, ON
Ms. Pamela Fralick	Canadian Physiotherapy Association	Toronto, ON
Mrs. Danielle Fréchette	The Royal College of Physicians and Surgeons of Canada	Ottawa, ON
Ms. Sylvie Gauthier	Health Canada	Ottawa, ON
Ms. Geri Geldart	River Valley Health	Fredericton, NB
Dr. Peter Glynn	PG Consulting & Saskatchewan Diagnostic Imaging Network	Kingston, ON
Ms. Emily Gruenwoldt	Association of Canadian Academic Healthcare Organizations	Ottawa, ON
Dr. Karen Gulenchyn	Canadian Association of Nuclear Medicine	Ancaster, ON
Dr. Calvin Gutkin	The College of Family Physicians of Canada	Mississauga, ON
Dr. Andy Hamilton	Interior Health Authority	Penticton, BC
The Right Honourable Stephen Harper	Prime Minister of Canada	Ottawa, ON

Ms. Moira Hennessey	Health and Community Services	St. John's, NL
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Ms. Lisa Maslove	Health Council of Canada	Toronto, ON

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