Wait Times without Rhetoric: Lessons from the Taming of the Queue

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Introduction

At the close of the fourth annual *Taming of the Queue* conference held in April 2007, conference co-chair Tom Noseworthy noted that with the issue of wait times, politics lay "around every corner." Indeed, the very fact that wait times (and the attendant issues of care guarantees, increased private delivery and payment for services and increased access to private insurance) are so highly political highlights is why events like the *Taming of the Queue* conferences are so important. The *Taming of the Queue* (ToQ) is now de facto an annual conference bringing together health care providers, system managers, policy-makers and researchers to examine the progress that Canadian (and international) jurisdictions have made in dealing with the complex array of factors that contribute to create unacceptable wait times for medically necessary services.

The event serves many functions. It is a showcase for success stories – local, regional and national. It is a venue for interjurisdictional comparison, whether between provinces and territories or between countries. It is about sharing knowledge across boundaries and the development of best practices that can serve as the model for others.

What perhaps distinguishes the ToQ conferences is the very fact that it has become an annual event and, as such, provides a regular and consistent snapshot of recent developments both in Canada and abroad. Taken together the four ToQ conferences are likely the most sustained pan-Canadian discussion that has ever been conducted on how the Canadian health care system can measure, monitor and manage wait lists within the system. And of all the discussions that have been held on wait times in the past decade or so, the ToQ events are also likely the most inclusive in terms of who has been sitting around the table.

While conference presenters and participants could hardly ignore their involvement in one of the country's most politically charged issues, the approach taken by those involved has been one of steadfast refusal to play into the easy political rhetoric that surrounds so much of the current conversation around this issue.

This can not always have been easy. Concern over wait times has resonated through provincial and federal politics for well over a decade. Critics of Canada's publicly administered single-payer system of health insurance have used the issue to argue that only increased market competition within the health care system will solve the long waits that some Canadians have experienced for some elective surgeries and services. Defenders of the single-payer system have argued that the issue is being overblown by those with an ideological axe to grind and that public confidence in the system is being eroded by irresponsible reporting of a relatively small number of cases of long waits.

Politicians, both federal and provincial and of all political stripes, have weighed in with promises of increased funding to deal with the so-called "big five" wait time issues of cardiac care, cancer care, joint replacements, sight restorations and access to advanced diagnostics and, most recently "care guarantees" for Canadians that would somehow ensure access to services. Even the Supreme Court of Canada made its feelings known by striking down Quebec's ban on the sale of private insurance for publicly insured services because of what it said was the government's inability to deal effectively with wait times and allowing people to die while waiting for necessary services.[1]

Yet despite all of the rhetoric about wait times, the *Taming of the Queue* conference has held fast to a very different approach. First, it is important to understand who was waiting for what services and for how long. Second, the system must be able to track people through the health care system in a manner that allows us to see where the bottlenecks occur and why they are happening. Third, the system must develop and test new processes for moving people through the care continuum in a more timely way without sacrificing the quality of the care they receive. Indeed, if done effectively, such processes should improve that quality. In other words, the system must measure, monitor and manage wait times and wait lists more consistently, rigorously, and effectively. And, finally, successful initiatives must be scrutinized objectively for the lessons they reveal that can be applied and adapted in other parts of the system and across jurisdictions.

In the final analysis, reducing wait times requires us to recognize the complex interplay of factors that create undue waits for patients in parts of the system and the complex interplay of the different policy levers (administrative, managerial and political) that have to be pulled simultaneously in order to address them.

So, it was something of an anomaly that Prime Minister Stephen Harper chose a luncheon address to the fourth annual *Taming of the Queue* to announce that the federal government had reached agreements with each of the provincial and territorial governments to provide funds from the federal "wait times trust" in exchange for each jurisdiction agreeing to meet specific wait time benchmarks in their jurisdiction. It was a political announcement at a decidedly non-political event but it served to highlight the very different approach that the *Taming of the Queue* conference takes to the issue of wait times.

The immediate effect of the announcement was to raise a number of questions about what, in the long-term, the federal-provincial agreements would mean. Media reports suggest that in many instances at least, the provinces and territories have agreed to meet benchmarks for individual procedures that they are, from their own reporting, already meeting. Furthermore, the individual agreements cover different procedures in different jurisdictions so that residents of one province have a "guarantee" of access to one procedure while residents of other provinces have "guarantees" for access to other procedures. And the announcement prompted a quite predictable question from the media to which there was no immediate answer – what happens to the patient who waits longer than benchmarked wait time for their service? Can they access care from a private

[1] For a discussion of the implications of the Supreme Court decision, see: Tom McIntosh. 2006. *Don't Panic: The Hitchhiker's Guide to Chaoulli, Wait Times and the Politics of Private Insurance.* Ottawa: Canadian Policy Research Networks.

provider at public expense? Can they travel to another jurisdiction or out of the country for the service at public expense? Can they initiate legal proceedings for redress of some sort?

While one should not expect a political announcement to answer in detail these kinds of questions, they remain the kinds of questions that must, at some point, be answered. And in thinking about those answers, one must reflect back on what one knows about the complex array of factors that can cause long wait times and the complex choices involved in reducing them.

Given that the *Taming of the Queue* conferences constitute the single most sustained conversation on these issues, it is important to understand how that discussion has evolved and changed over the past few years – to think through the lessons that have been learned since the first gathering in 2004. What follows then is an attempt to crystallize the lessons from the past four events – drawing on the conference reports and presentations[2] – in an effort to leave aside much of the rhetoric that surrounds most discussions of wait times in Canada (and, it appears, elsewhere) in order to try to understand where we were when we started the conversation, where we are now and, most importantly, how we got there. Understanding that path and what we learned along the way will go some of the way toward understanding how much further we have to go and what to make, ultimately, of announcements like that made by the Prime Minister.

ToQ I (2004): What Is a Wait List, Anyway…?

Of course, originally ToQ I was simply "The Taming of the Queue." The idea that it would become an annual event likely did not cross the organizers' minds until sometime during the first conference, when it was apparent that no conclusive discussion on such a complex and politically charged issue could be had in just two days.

What is fascinating about this first conference is how, in a sense, tentative so much of the discussion appears. The first half of the presentations and discussion was about the different perspectives one can take on the issue – the public's view, the media's view, the legal view and the data developer's view. This first conference had three key objectives:

1. To explore the underlying factors that drive waiting times for health services;
2. To share research and experiences with wait time measurement and monitoring among a broad cross-section of stakeholders; and,
3. To identify the policy implications of improved wait time measurement and management from the perspective of payers, providers and patients.[3]

The first conference made a number of things clear. First, Canada is far from alone in having a concern about wait times, with providers, the public and health system managers all feeling that it was an important issue to be dealt with. According to a report from the OECD, half of its member states reported wait times as a serious issue. Second, there were serious debates within most nations about how to measure wait times – from general practitioner referral to specialist,

[2] The conference reports and the presentations from the past four *Taming of the Queue* conferences are all available on the Canadian Policy Research Networks' Web site at www.cprn.org.

[3] Fooks, Cathy. 2004. *The Taming of the Queue: Wait Time Measurement, Monitoring and Management*. Ottawa: Canadian Policy Research Networks, p. 1.

time waiting for surgery after consultation or median waits for time on the list – as well as over whether to tackle wait lists with initiatives aimed at the supply side, the demand side or some mixture of both.

Most importantly though, the conference demonstrated that there were already initiatives underway to develop better ways of measuring and monitoring wait lists (e.g. the Western Canada Wait List (WCWL) project) and better ways to manage lists (e.g. the Saskatchewan Surgical Care Network). There were new initiatives aimed at specific diseases such as the Cardiac Care Network of Ontario and Cancer Care Ontario as well as initiatives in specific regional health authorities from Nova Scotia to Alberta. All of these initiatives were based on a couple of fundamental elements:

- Increases in supply were not successful in themselves and had to be matched with attempts to influence demand as well;
- Data collection had to be improved and lists managed centrally;
- Leadership within the system from physicians and from within government was important to changing behaviour;
- The system needed more standardized tools for assessing patients on lists in order to determine treatment priorities.

What was not evident in the discussion at this first conference was any serious discussion that the fundamental principles of the single-payer, publicly administered system in Canada needed to be abandoned. Solutions to the wait time problems, which everyone admitted were real and needed to be tackled, could be found within the general framework or infrastructure of the existing system. The progress made by initiatives like the WCWL and Cancer Care Ontario demonstrates clearly that there is the ability within the publicly-financed system to deal with wait lists provided that both the necessary resources and leadership are present and sustained.

ToQ II (2005): Learning to Learn from Each Other

The second ToQ conference, held exactly a year later in Ottawa, provided (perhaps for the first time) a thorough discussion of wait list initiatives across the country. Representatives from governments, regional health authorities, individual institutions and policy researchers within each province provided what was termed a "cross-country check-up" on developments in each jurisdiction – sometimes outlining broad, multi-faceted province-wide initiatives, sometimes focusing in on specific initiatives in single institutions or regional health authorities.[4]

What was evident from the discussion was that jurisdictions were actively working to overcome the barriers that often prevent individual jurisdictions in Canada from learning from each other. It is an oft-noted frustration of Canada's federal nature and division of constitutional powers that while it may in fact contribute to allowing for innovations to take place inside smaller provincial laboratories, it also sometimes frustrates the ability of those innovations to move across borders as "best practices." It may well be the case that Canada's publicly administered health insurance

[4] McIntosh, Tom. 2005. *The Taming of the Queue II: Wait Time Measurement, Monitoring and Management*. Ottawa: Canadian Policy Research Networks.

system would not exist nationally had it not been able to be first developed in the relatively small jurisdiction of Saskatchewan, but it is also the case that what happens in one province does not always jump across borders very quickly or easily.

Yet it is clear that there is a line of development that can be traced from, for example, the implementation of Ontario's Cardiac Care Network to the work of the WCWL project to to the development of Saskatchewan's Surgical Care Network. Provinces were, it was reported, actively building on the successes of their neighbours and of other countries.

But it was also evident that the different provinces were all at very different stages of progress in dealing with wait times – some only beginning to make progress on appropriate data collection while others could already begin to point to lowering wait times in some of the more pressing areas. And, as well, the initial progress being reported often went hand in hand with the conclusion that wait lists were themselves sometimes simply the symptom of other health care system challenges in the areas of health human resource planning, information technology infrastructure shortcomings and primary health care reform issues. As the wait lists were increasingly better measured and monitored, it was apparent that the real challenges in their management led to the conclusion that wait lists could not be treated in isolation from the rest of the health reform agenda.

The conference concluded with the articulation of a future research agenda focused on three key areas:

1. Patient-focused research, including dealing with patient expectations in light of technological and other advances in treatment and the issue of "uncertainty" faced by patients waiting on lists;
2. Wait list management research, including refining the patient assessment tools already under development and understanding the relative strengths of the different models being used across the country;
3. Health human resources research, including understanding how wait lists could be influenced by changes in HHR planning across multiple professions and how much of the current situation with wait times is a result of deeper problems in health human resources planning within the system.

Finally, there was a significant discussion of the need to begin to include patients and the public more fully in the discussion of wait time management. Patients and the public can no longer be left out of the discussions over how best to proceed and initiatives have to include significant supports for patients in order to ensure that they are not left to navigate the wait for care on their own. Initiatives that might either implicitly or explicitly confront the issue of rationing within the public system could not proceed without the public's acceptance that this was an appropriate course of action.

ToQ III (2006): Inching towards Care Guarantees?

The 2006 iteration of the *Taming of the Queue* occurred at a unique political juncture in the public debate over wait times in Canada. The 2004 First Minister's Accord had provided funds to provinces for wait time initiatives in what would come to be known as the "big five" areas of public concern – cancer care, cardiac care, diagnostic imaging, joint replacements and sight restoration (i.e. cataract) surgery. In 2005, the Supreme Court of Canada weighed in on the wait time debate in the Chaoulli case by ruling that prohibitions in Quebec's health insurance legislation against private insurance contracts for publicly insured services and private payment for hospital services had violated Quebec's Charter of Rights and Freedoms.[5] The 2006 federal election had ended 13 years of Liberal government and brought a newly united Conservative Party into power with a minority government. And the new Prime Minister, Stephen Harper, had made the implementation of "care guarantees" one of the five priorities of his new government.

Thus, much of the focus of the conference this year was on both the progress being made in the "big five" areas (with some not insignificant concern that the focus on the five areas would have negative consequences for wait times for other procedures not yet deemed a priority by the public or by governments) and the challenges involved in taking the benchmarks already in place or under development and turning them into something that might be considered a "guarantee" of access to services for Canadians. Indeed, the worry that the very use of the word "guarantee" might raise public expectations to a degree that could not be met and, thus, turn the health care system over to litigation was a consistent concern expressed over the two days.

The conference, which had a greater international focus than its immediate predecessor, but which also included, once again, a reasonably comprehensive cross-Canada survey of progress, identified both a series of key success factors for wait time management as well as a series on new and ongoing challenges that needed to be confronted if progress was going to continue.[6]

The success factors can be summarized as follows:

1. Sustainable and consistent funding for human resources, infrastructure and to sustain the commitment of system managers to specific initiatives;
2. Leadership by clinicians, researchers, system managers and governments for both the implementation of initiatives and to manage the change within the system that such initiatives require;
3. Increased interjurisdictional learning and cooperation combined with a willingness to engage more effectively with the public, with patients and with those inside the system itself.

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5 McIntosh, Tom. 2006. *Don't Panic: The Hitchhiker's Guide to Chaoulli, Wait Times and the Politics of Private Insurance*. Ottawa: Canadian Policy Research Networks.

6 Torgerson, Renée, and Tom McIntosh. 2006. *The Taming of the Queue III: Wait Time Measurement, Monitoring and Management: Where the Rubber Meets the Road*. Ottawa: Canadian Policy Research Networks.

The challenges can be summarized as follows:

1. The implementation of care guarantees had to be done extremely carefully so as to not unduly raise public expectations, not transfer the management of wait times to the judicial arena and in a manner that does not divert resources from other parts of the health care system;
2. The health care system had to begin to confront the issue of "appropriateness" of care to ensure that demand for services was based on clear guidelines for the utilization of services;
3. The need to not become overly focused on the "big five" areas to the exclusion of others lest the system inadvertently create wait lists in other areas within the system and further marginalize services to vulnerable populations;
4. Ongoing challenges in collecting data in a manner that makes reasonable comparisons across jurisdictions possible;
5. Public education and involvement in setting priorities
6. Human resource planning within the system needs greater attention as new initiatives come on line.

For the first time, it was clear that developments in the political arena had cast a significant shadow over the conference. Despite reports that there was real progress to report from across a number of jurisdictions where wait times for specific services were being effectively reduced and managed, there was a real concern that the political expectations created by the promise of "guarantees" of access to key services could set back the progress that was being made if they were implemented in a too hasty or ill-considered manner.

Little time had been spent in the election campaign on explaining to Canadians exactly what would be "guaranteed," what would be done if the guaranteed time was not met or how the guarantee would be put into practice. Coupled with the fallout from the Supreme Court decision – widely criticized for its ignoring of the actual evidence about wait times in Canada – the optimism engendered by the reports of real progress in wait time management was tinged with concern that the political rhetoric over wait times was threatening to once again overshadow reasoned analysis and discussion.

ToQ IV (2007): Getting beyond the Big Five

If politics was a somewhat shadowy presence at the 2006 meeting, then it was, as was noted above, a lunch guest at this year's *Taming of the Queue*.

The conference presented, once again, a mix of international and domestic illustrations that:

1. Wait times remain an issue across a whole range of health care systems and that cross-jurisdictional learning remains as vital as ever; and,
2. Canadian jurisdictions continue to make progress in managing wait times and to do so within the framework of the publicly administered system.

But there also remained some very hard work 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 greatly benefit from the hard work already done in those areas that have seen 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 different ways:

1) Successful solutions require action on multiple fronts, for they are as complex as the problem of wait times themselves.
2) Collaboration, information sharing and learning from the experience of others is the key to adapting successful wait time strategies in different contexts and environments.
3) There are health human resource issues always in the background and wait times can not be reduced without due consideration given to the staffing needs of the system and to ensure the quality of care.
4) Priorities for action are important, but attention must always be paid to 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.[7]

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 inculcate a new culture inside health care institutions and within governments to ensure that there are adequate resources to both begin and carry through with the transformations required.

[7] McIntosh, Tom, and Patrick Fafard (with Zeina Abou-Rizk and Tina Lafrance). 2007. *Taming of the Queue IV: New Frontiers of Wait Time Measurement, Monitoring and Management*. Ottawa: Canadian Policy Research Networks.

Learning Lessons and Leaving the Rhetoric Aside

For well over a decade, the Canadian media has been filled with a seemingly endless stream of stories about individuals waiting egregiously long times for medically necessary services. There is no doubt that there is a real problem with wait times for some procedures in some parts of the provincial and territorial systems across the country. This reality is reflected by the priority given to the wait time issue by the public in poll after poll and by federal, provincial and territorial politicians from all parties across the country. And none of the researchers, clinicians, policy analysts or government officials who have participated in the *Taming of the Queue* conferences has ever denied the very real problems that exist.

But they have also insisted that any real analysis of the issue – from the question of actually defining what it means to wait through to the question of what approaches to reducing wait times work best in what political, economic and social context – begin with hard data and scientific evidence. From the very first conference there was the insistence that the discussions be guided by evidence and analysis rooted in that evidence.

At the same time, politics has never been far from the discussions or the concerns of the researchers. How do we translate the progress we can measure to the public in a manner that bolsters their confidence in the system? How do 14 jurisdictions collaborate effectively to manage a common problem? How do "benchmarks" get communicated to the public in a manner that will not raise expectations inappropriately? How do we manage wait times within a system that is rooted in the proposition that access should be based solely on need when a consumerist culture encourages us to see all goods and services as commodities to be purchased? How do we talk about "guaranteeing" access to services in a way that does not lead us into turning resource allocation questions over to the courts?

At one point or another, all of these questions have either been front and centre in the discussions or have, at least, lingered in the background at the conferences. In any event, they have never been ignored by the participants.

Yet the one consistent message from the four conferences held to date is that the issue of wait times, while serious, is not unmanageable within the framework of the current system. Yes, the system still needs to make reforms in other areas that would greatly enhance our capacity to deal with wait times more quickly and more effectively – more progress on primary health care, more integration of services from across the continuum of care, better coordinated health human resource planning, etc. – but even with those areas still acting as barriers to wait time management, progress is being made. Benchmarks are being developed, implemented and met and new systems for measuring, monitoring and managing wait times are having an effect in providing better access to services for Canadians in need.

Unfortunately, incremental and admittedly uneven progress is deemed less newsworthy than parading a sick patient, who has waited too long, in front of the cameras. And reports that describe the system as in a terminal crisis that can only be saved by abandoning its commitment to serving need over ability to pay make better headlines.

What distinguishes the *Taming of the Queue* conferences is the fact that they have consistently reflected the depth of the challenge that wait time management poses for the system. Long waits are the result of a complex interplay of factors on both the demand and supply side of the equation. Thus, the solutions to those long waits lie in the complex interplay of multi-faceted initiatives that mix new resources, new data collection, new management techniques, different allocations of human and other resources, and sustained leadership inside and outside of the system. And, despite what some voices in the system insist, these changes take time not only to implement but to implement effectively.

The goal here has not been to simply put a happy face on the issue of wait times, but rather to look seriously at the evidence once it has been stripped of the overheated rhetoric that often surrounds much of the popular discussion of the issue. In doing so, one sees the Prime Minister's recent announcement in something of a different light. For some, it is a small step in the right direction insofar as it entrenches some form of a commitment from each government. For others, it is a distraction from the real issues that the system still faces in measuring, monitoring and managing wait times across the system insofar as many of the agreements appear to be commitments to do what governments are already doing.

The rhetoric of "mission accomplished" aside, the real progress on reducing wait times within the system has been made through the dedication of the clinicians, researchers and analysts working within the public system to revamp how we measure, monitor and manage the wait lists. It has relied on their leadership and their understanding that the mission is an ongoing one to be engaged on many fronts over many years in order to achieve the measurable progress that we have seen in recent years.

In the final analysis, we are likely a long way from being able to say that we have eliminated wait times as a serious issue for the health system in Canada. But we can say that we know more about and have done more to reduce wait times in the last few years than the system is often given credit for. We are still a long way from a "care guarantee" (at least the kind of guarantee the public is expecting). But then, given that there remain a multitude of questions about how a guarantee gets implemented and what it means for patients, providers and those who run the health system, that may not be a bad thing at this point. In the meantime, the wait times will continue to come down across the country and, rhetoric aside, that is all that matters.