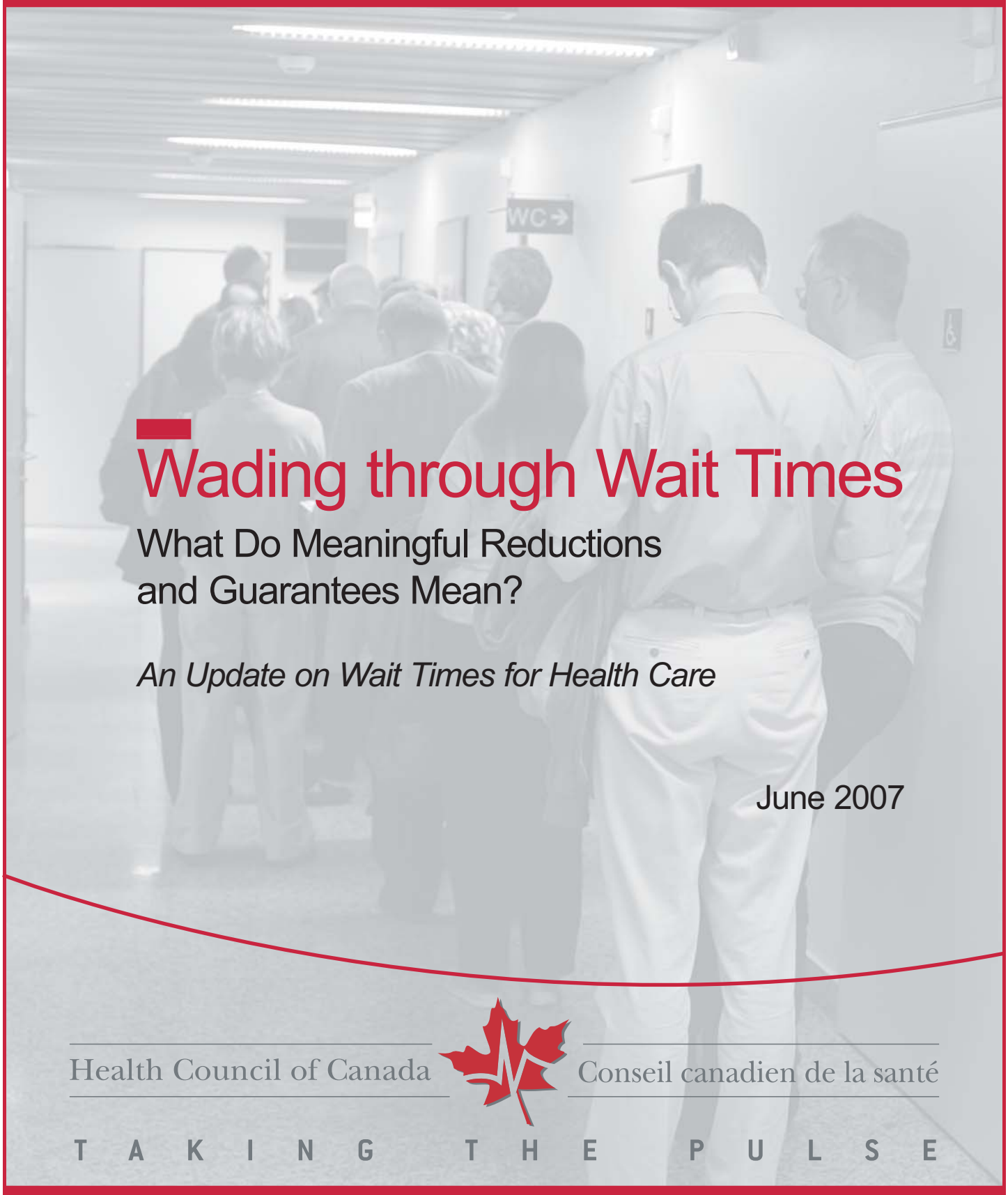

Wading through Wait Times

What Do Meaningful Reductions and Guarantees Mean?

An Update on Wait Times for Health Care

June 2007

Health Council of Canada | Conseil canadien de la santé

T A K I N G T H E P U L S E

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FRANK'S STORY

Having fallen off his bicycle, and after his second visit to the hospital and a second X-ray, Frank was diagnosed with a hip fracture in 2002. Surgery mended the break, but three years later when he was 57 years old, Frank began to experience pain and difficulty walking long distances. Even during everyday activities, he walked with a limp. After an MRI confirmed the need for further investigation, Frank was referred to an orthopedic surgeon who did hip replacements.

Frank waited five months to see the orthopedic surgeon, who diagnosed the need for a full hip replacement—surgery to replace the damaged bone with an artificial joint. Frank was again on a waiting list, one managed, as best as he could tell, by one person in his surgeon's office "without consultation with other surgeons' offices or the hospital department, and with no prioritization of cases, at least beyond the cases about to be performed."

Periodically, Frank made calls to the surgeon's office to inquire about his place on the list. Nobody seemed to know. There had been some delays due to the surgeon's own health. Frank continued to call until he finally got a date for surgery—nearly one year after his need for a hip replacement was confirmed. Six weeks after he received his new hip, Frank says, "I was walking better than I had in at least a year and a half, and without a limp."

We know from the data and narratives in this report that Frank's experience, a true story, is not the case for every Canadian. But to illustrate how patients can be affected by policy changes, we revisit Frank's story at various points to help us wade through the current issues related to wait times for non-urgent health care.

INTRODUCTION

Waiting for necessary care is difficult whether you are a nine-year-old boy waiting to see a mental health specialist or a 57-year-old man waiting for hip surgery. Waiting too long may worsen your health problem or may create anxiety that affects your ability to function day-to-day.

Long waits for care also affect the performance of the health care system. For example, when too many people wait too long for care there are extra administrative costs associated with managing wait lists, as well as costs associated with treatment complications that can arise because of the patient's wait.

About one in 10 Canadians see a health care specialist each year, and many report experiencing waits for this care.[1] In surveys in 2003 and 2005, Canadians reported waiting about four weeks to see a specialist on average, with very little change between the two years. One in five people who saw a specialist (21%) said that they had difficulty getting care, and among these people, two-thirds (68%) felt that their wait for care was too long. Canadians also reported in both 2003 and 2005 that wait times created barriers to non-emergency surgeries and diagnostics tests that they needed to receive. While we have pockets of information about how long Canadians wait for specialized care, we have very little information about how these waits affect people's well-being or that of the health care system.

The focus on five

In the 2003 *First Ministers' Accord on Health Care Renewal*, the prime minister and premiers committed to timely access to services for their citizens. In the *10-Year Plan to Strengthen Health Care*, signed in 2004, they further committed to achieve, by March 31, 2007, "meaningful reductions in wait times in priority areas such as":

- Sight restoration (surgery to remove cataracts)
- Diagnostic imaging (for example, MRI, CT scans)
- Cancer care (for example, surgery and radiation therapy)
- Cardiac care (for example, bypass surgery)
- Joint replacement (surgery to implant artificial hip and knee joints)

Wait times have been a top-of-mind concern for Canadians for many years: people want to feel confident that health care services will be available when they need them. In response, federal, provincial and territorial governments made commitments in 2004 to reduce wait times in five priority clinical areas. The federal government created the $5.5-billion Wait Times Reduction Fund, which provinces and territories are using to invest in reducing wait times for health care. This 10-year fund will be available until 2014.

With this update, the Health Council of Canada reports on the country's progress in reducing wait times for care, particularly in light of the national commitment "to achieve meaningful reductions in wait times" in priority health care areas by March 31, 2007. This report focuses on wait times for *non-urgent* care; emergency health care needs in Canada are handled on an urgent basis. We start with a

reminder of what governments agreed to do in 2003 and 2004, and what the Health Council found in our earlier reports. We bring together information from the provinces and territories, recently published reports, and interviews about selected programs, and we conclude this section of our report with three key messages:

1) There is a significant amount of activity underway in every jurisdiction to improve waiting times for care.
2) In some jurisdictions and for some services, data are available to show that wait times have declined, in some cases dramatically.
3) But the information needed to paint a cross-Canada picture—information that allows Canadians to see changes over time and to compare wait times data from different parts of the country—is not available from all jurisdictions, despite widespread recognition that it should be.

To conclude here, however, would not do justice to the activity that governments have invested in. So, as the Health Council has done in past reports, we also shine a light on selected programs to illustrate the significant changes that are transforming health care in Canada. Through interviews with some of the people leading these changes, the five stories located throughout this report represent activity to improve access to care in each of the five priority clinical areas. Some of the stories describe well-established activities, with strong results to demonstrate their value, while others are relatively new. During our interviews, a number of themes emerged about key factors for success in reducing wait times for health care. These success factors are:

- Support from government leaders;
- Strong program leadership that brings together administrative and clinical champions;
- Full-time staff who are dedicated to making the program work;
- Information systems that enable programs to centralize waiting lists, to track wait times in local areas and province-wide, and to share this information publicly;
- Adequate funding for the introduction of information systems and effective program leadership;
- A broad, comprehensive approach to the many large and small changes required to reduce wait times for care.

From these initiatives it appears to us that, at least in some parts of the country, Canadians should soon be in a position to know more clearly what progress has been made in reducing waiting times for care. We encourage leaders who are working to reduce wait times in their own areas to learn from the numerous programs underway.

Finally, we end this update by reporting on the new "patient wait time guarantees," which the federal government announced in Budget 2007, and we look at some of the questions Canadians may have for their jurisdictions in the wake of these announcements.

SHINING A LIGHT...

Cardiac care in Ontario: back to the future

When people are referred for heart surgery in Ontario, they get a glimpse into the future in two ways: they receive a personalized estimate of approximately when they can expect to receive their procedure, and they get plugged into a system of managing access to care that many still consider a vision of how things can be.

For the Cardiac Care Network of Ontario (CCN), that future began 17 years ago. Born out of public outcry that patients were dying on wait lists for heart surgery, CCN was established in 1990 to advise the provincial Ministry of Health on advanced cardiac care services for adults and to coordinate ways to improve those services. Typical of so many moments in the history of wait times management, there was nothing that could be called a "system" to coordinate access to care.

"Waits were short in some centres and long in others, and nobody knew each others' lists," says Heather Sherrard, Acting Chief Executive Officer of CCN and Vice-President of Clinical Services at the University of Ottawa Heart Institute, one of 17 cardiac centres now part of the provincial network. Whether you received care quickly or waited longer depended on where you lived, not on whether your need for care was urgent or you could safely wait. The key task for CCN was to create a system that could rapidly move people up the queue and between centres if their condition deteriorated. That required a central database, an urgency rating system, and a way to keep in touch with patients while they waited. Enter a new job title: Regional Cardiac Care Coordinator.

Today, depending on the range of services provided, each cardiac care centre in Ontario employs one or more cardiac care coordinators. These people are the link between the patient, their family doctor, their cardiac specialists, and the hospitals. When a family doctor refers a patient for heart surgery, the regional coordinator enters the patient's information in CCN's province-wide database. Based on medical guidelines for care and the individual patient's condition, the database generates a "maximum recommended wait time" for the patient—the longest time that he or she can safely wait for the procedure. Coordinators send the patient a package of information about his or her expected wait, while also giving this vital information to the family doctor. In addition, because coordinators have access to information about all patients waiting, they are able to tell patients approximately how long they will likely have to wait.

"The package tells patients: you are in a provincial network and your recommended wait time is, say, six weeks. If you don't want to wait that long, or if you develop symptoms, call your coordinator," Sherrard explains. If patients approach their maximum recommended wait time, the coordinator calls to let them know and to discuss options: they can decide to move the location of their procedure or they can continue to wait and monitor their condition. "At first, it was not easy to move people," recalls Sherrard. "Now it's very smooth and quick, although relatively few patients choose to move."

Moving patients is not often necessary because "wait times are much improved," Sherrard says. "It took 10 years of managing lists and increasing the volume of procedures performed—through a time of growing need from the baby boomers aging. But waits are relatively stable, for now." The cardiac system is "in a reasonable position" to continue to respond to population trends in age and disease, she adds, and "we are carefully watching the lists because of our concerns about rising diabetes and obesity."

CCN's website, *www.ccn.on.ca*, reports statistics since 2004, and the data show that there has been progress in meeting recommended wait times across the board for cardiac care, with the strongest improvements in elective surgery. As of March 2007, 96% of elective bypass surgeries were done within their recommended wait times, compared to 86% in 2004. For cardiac catheterization, 98% of cases were completed within recommended waits in early 2007, up from 82% three years ago. Regional disparities in wait times have also decreased. CCN measures these as the gap between the regions with the second best wait time and the second worst wait time. Since 2004, the disparity gap for elective bypass surgery has dropped by 50% (from 40 days to 20) and by 84% for elective catheterization (from 63 days to 10).

Nearly as often as they speak with patients, coordinators also field calls from family doctors and specialists. It took time to develop the trust required for physicians to hand over to a central system the management of their patients' waiting, Sherrard acknowledges. Strengthening the flow of information is one way CCN has built a solid reputation, she says. For example, family doctors receive results of their patients' tests and procedures within 24 to 48 hours.

An emerging focus on prevention of cardiac health problems is designed to strengthen CCN's link with primary health care and to support the 20% of CCN patients who do not have a family doctor. "This is a natural next step," says Sherrard. "All of the conditions we deal with have underlying chronic disease. The better you manage that disease, the less need there will be for future cardiac procedures." CCN is evaluating several tools to help ensure that, when patients are discharged from hospital, their follow-up care reflects the best advice of experts in the field. In one trial project—the patient discharge tool—patients receive a "contract," with a copy for their family doctor, that explains in plain language their follow-up care based on guidelines from the Canadian Cardiovascular Society. Another project is testing the impact of an automated message system that phones patients to remind them about their individual plan for self-care, such as taking aspirin to reduce the risk of heart attack.

"We're closing some of the holes in the system," Sherrard says. "Hospitals see the patients so briefly, and most hospitals have no way of knowing what happens to patients after they leave." CCN is also working with the Heart and Stroke Foundation of Ontario on projects to promote healthy weights for children and prevent high blood pressure—so that fewer people need to become part of the CCN database in the future.

What did governments promise about wait times in the 2004 10-Year Plan to Strengthen Health Care?

- Each jurisdiction agrees to establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be developed by all jurisdictions by December 31, 2005.
- Evidence-based benchmarks for medically acceptable wait times, starting with cancer, heart, diagnostic imaging, joint replacements, and sight restoration, will be established by December 31, 2005, through a process to be developed by federal, provincial and territorial ministers of health.
- Multi-year targets to achieve these priority benchmarks will be established by each jurisdiction by December 31, 2007. (See page 20 for explanations of the terms *benchmarks* and *targets*.)
- Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait times targets.
- Provinces and territories will achieve meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements and sight restoration by March 31, 2007, recognizing the different starting points, priorities, and strategies across jurisdictions.
- The Canadian Institute for Health Information will report on progress on wait times across jurisdictions.
- The federal government will establish a Wait Times Reduction Fund of $5.5 billion available over 10 years to augment existing provincial/territorial investments.

THE COMMITMENTS

In 2003 and 2004, the prime minister and premiers (First Ministers) met to discuss and agree on government investment to reduce wait times, among other health care issues. The result: a set of commitments and deadlines related to wait times, access to care, and reporting to Canadians on their progress.

In earlier reports, the Health Council has commented on the pace of change towards meeting these commitments. In our annual report to Canadians for 2004, *Health Care Renewal in Canada: Accelerating Change*, the Health Council made the following recommendations towards managing and reporting on wait times:

1. Ensure a comprehensive approach of measuring, monitoring and managing wait times and access to care because that is the only way to protect equity between areas of competing demand for limited health care resources. Care must be taken to ensure that attention and resources are not solely dedicated to those areas being tracked, such as surgical interventions, as opposed to whole patient management.
2. Make publicly available reliable and comparable information on wait times to promote a better understanding of the issues involved.
3. Evaluate the outcomes of health care interventions to ensure that thresholds are set appropriately and that health care resources are used as cost-effectively as possible.
4. Engage key players to review each step in the treatment journey and simplify, speed up or eliminate processes in order to dramatically improve wait times.

5. Create appropriate reward systems so that all clinicians, managers and administrators strive for reduced wait times.
6. Direct new funding explicitly to reduce wait times to ensure that all resources are coordinated and available at the right time and place.

In response to the passing of the deadline to establish pan-Canadian benchmarks by December 31, 2005, the Health Council noted in a supplemental report[2] that the provinces and territories had agreed on medically acceptable wait times for radiation therapy, hip fracture repair, hip and knee joint replacement, cataract removal surgery, breast and cervical cancer screening, and cardiac bypass surgery. They had not—and still have not— established pan-Canadian benchmarks for diagnostic imaging nor have they established comparable indicators of access.

In *Health Care Renewal in Canada: Clearing the Road to Quality*, our annual report to Canadians for 2005, we called for improved public information on wait times so that Canadians could determine how long they should typically expect to wait for treatment. We also called for a common service queue (a centralized waiting list) for each of the major health care services; a central information system that identifies patients whose waits are becoming unusually long; an appeal process for patients who feel they are waiting too long; and secure real-time wait-list registries to assist the people who manage waiting lists for care. We also restated the need to focus on assuring that care is appropriate and leads to the best possible health outcomes. In other words, programs should focus on the quality of health care while they also work to improve access to necessary care.

In *Health Care Renewal in Canada: Measuring Up?*, our annual report for 2006, the message

Other Health Council of Canada publications on wait times and access to care

All Health Council publications are available for free download at *www.healthcouncilcanada.ca*.

1. *10 Steps to a Common Framework for Reporting on Wait Times* **(November 2005):** This brief technical report makes clear the need for common terminology and measurements to evaluate the nature of wait times for health care in Canada. It proposes 10 possible ways to better manage wait times through better information, including: prioritize cases on the basis of urgency, using a system of no more than three levels of urgency; and report wait times using percentiles (the percentage of cases completed within the acceptable wait time or benchmark) instead of reporting average or median wait times.
2. *A Background Note on Benchmarks for Wait Times* **(November 2005):** This short report was released the month before the provincial and territorial governments were due to announce pan-Canadian benchmarks for certain clinical services. To help Canadians understand the public debates and pronouncements about benchmarks, this report uses a question-and-answer format to define *benchmarks* and *targets* and provides a brief history on government commitments related to benchmarks for medically acceptable wait times and their progress to date.
3. *Wait Times and Access* **(January 2005)***:* This background paper to the Health Council's first annual report to Canadians, *Health Care Renewal in Canada: Accelerating Change*, addresses why timely access is an issue; why waits occur; what has been done to improve timely access; and what we might do to overcome impediments and improve progress.

for better data was central. For example, we noted that a key problem with health care waiting lists in many parts of Canada is the lack of coordinated processes to verify and manage the lists. The Health Council advised that:

1. Governments must continue to assess whether reducing wait times in the five targeted areas is crowding out wait times for other services.
2. Governments must ensure that the urgency of the patient's condition is being factored into the patient's placement on the waiting list, and that there is some mechanism to monitor that it is.
3. Jurisdictions should develop their own centralized registry of wait times for **all** procedures. Centralizing the management of data collection increases the likelihood that it is accurate and comparable.
4. Jurisdictions should move as quickly as possible to provide real-time, hospital-specific information on wait times through government websites readily accessible to residents/patients.
5. Jurisdictions should include wait time information at **all** facilities, even those not participating in the Wait Times Reduction Fund, and over time, expand the reporting process to non-targeted procedures as well.

With the passing of the March 31, 2007, deadline for provinces and territories to achieve meaningful reductions in wait times in the five priority areas, as agreed to in the 2004 10-year plan, the Health Council takes this opportunity to update Canadians on what our provincial and territorial governments have done to meet this commitment.

SHINING A LIGHT...

Cancer care in Nova Scotia: wait times are one piece in the continuum of care

"We look at wait times not in isolation but as one piece in the continuum of care," says Brenda Payne, Executive Director, Acute and Tertiary Care, in Nova Scotia's Department of Health. Taking that broad approach has meant a number of things. It's meant looking at demographics to project demand for services. The Atlantic region is experiencing a more dramatic shift towards aging than other parts of the country: in Nova Scotia, deaths outnumbered births last year, and cancer diagnoses (just one of several major illnesses associated with aging) are expected to increase 30% by 2020, according to a report last year by Cancer Care Nova Scotia. It's also meant looking at geography—at how the province can better serve it's largely rural population. And, among many other activities, it's meant coordinating the planning and monitoring of services, so that information is available to explain what's working well and what is not.

Using breast cancer as a case in point, Payne describes the province's successful breast screening program, which is credited with improving access to early detection of breast cancer and improved survival. She notes that, based on Nova Scotia's unique mammography database, 58%* of women 50–69 years old received a mammogram (either for screening or diagnosis) within the past two years, a rate that has nearly doubled since 2000 and is approaching the national target of 70% for women in that age group.

One factor in this progress are three mobile screening mammography units, which have dramatically improved access to routine mammograms. The units travel to communities identified through a "relatively inexpensive" geographic information system that can plot where women in the target age group are living, Payne explains. The units set up in convenient locations such as shopping centres and can be staffed by a single person. Women don't need a referral to receive a mammogram through this program. Access to screening mammograms in hospitals has also improved: average waiting time declined from 44 weeks to 11 weeks between 2005 and 2006.

Women with an abnormal result will then need a follow-up test. Wait times for this next step have been reduced as well, from an average of eight weeks in 2005 down to two weeks in March 2007. A central booking system, which the province has been phasing in since 2000, has helped by ensuring that women without symptoms of breast cancer get their mammograms at screening facilities, freeing up staff and equipment to carry out diagnostic tests.

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* This rate differs from the rate of 49.9% for Nova Scotia published in the recent report *Health Indicators 2007* from the Canadian Institute for Health Information (CIHI), available at *www.cihi.ca*. CIHI's rates for screening mammography are based on surveys conducted by Statistics Canada in which Canadians report on their own health and use of health care services.

The real measure of success is better health for Nova Scotia women. Payne reports that, since 1998, the number of women with invasive breast cancer has decreased by 13% and, for women who do develop breast cancer, survival rates have risen by 4%. Many factors contribute to better outcomes, particularly in a field as complex as cancer care, but early diagnosis and faster care are certainly part of the picture. In the area of cancer treatment, the province has made new investments in staffing and technology, such as updated radiation equipment.

The province recently released a three-year strategy, *Timely Access to Healthcare in Nova Scotia: Improving Wait Times 2007 – 2010,* that outlines a number of goals, including: getting meaningful, reliable information to shorten waits for care; investing in the right people, equipment and technology to provide safer, faster care; and moving care as close to home as possible. Nova Scotia is applying the same approach to other areas, such as access to MRIs, pain management, and children's mental health services. A key theme through these changes, Payne says, has been "keep your eye on the target and a handle on all the factors that influence access to care."

MEANINGFUL REDUCTIONS IN WAIT TIMES: HAVE THEY HAPPENED?

Undoubtedly, there has been progress in reducing wait times for some health care services in some areas of Canada. But in order to demonstrate to the public whether wait times are getting longer or shorter, or not changing at all, jurisdictions need to identify how long the wait time was to start with. They need a baseline measurement to mark the starting point of their progress. They need to report data, consistently collected from across their jurisdiction.

In the years prior to the First Ministers' accords to reduce wait times for specific areas such as hip replacements, there were few information systems in place that could give patients like Frank, their doctors or hospital managers the ability to measure and manage waiting times for care. There were, for example, few places collecting information about wait times for specific surgeons. There were virtually no systems to share information between surgeons so as to offer patients the opportunity to shorten their waits by changing doctors, and there were few places that health care managers or providers could track how long patients were waiting on average for specific types of care. And there were certainly no public websites where patients themselves could find out what their wait times were likely to be.

In order to demonstrate progress in reducing wait times, we also need to know how long patients can reasonably wait for various types of health care. How long is it medically acceptable to wait? In other words, what is the benchmark for a safe, medically acceptable wait time.

> ***What does this mean for people like Frank who wait for health care?***
> *In Frank's case, the provinces and territories had agreed in December 2005 that the pan-Canadian benchmark for hip replacement was 26 weeks (six months). Clearly, Frank's experience—he received his surgery nearly a year after the specialist referred him for the procedure—went beyond the benchmark for hip replacements. This is despite the fact that his need for hip replacement surgery was diagnosed in February 2006, in the post-benchmark era. Frank's experience also suggests that there is considerable room for improvement in coordinating information about waiting lists, in centralizing ways to improve access to timely care, and in letting patients know how long they might have to wait.*

One area in which all provinces have made progress in the past few years is in reporting wait time information to their citizens through publicly accessible websites. Most provincial governments have established dedicated websites where Canadians can see how long people typically wait for specific procedures or specialist appointments. Newfoundland and Labrador publishes quarterly wait time updates, and the Northwest Territories and Prince Edward Island provide periodic wait time information through government press releases.

While this information is not yet sufficient for Canada-wide monitoring, the fact that it is in the public realm in so many jurisdictions is a significant step forward. Until recently, as Frank's story illustrates, most surgeons kept their own waiting lists and these data were rarely compiled at the provincial level. Moving wait time information out of doctors' offices and onto the Internet has been no small task. And these websites would not be possible unless governments had devoted significant resources to building centralized information systems that provide the building blocks for managing wait times. As all of our five "shining a light" stories show, these information systems ensure that patients can be put in line fairly and equitably, based on the urgency of their need for care; they support the ability of doctors and hospitals to schedule patients; and they enable patients to know approximately where they are in the queue.

In our February 2007 report *Health Care Renewal in Canada: Measuring Up?* we reported information from provincial websites suggesting that, where it is measured, there is evidence that wait times for hip replacements and knee replacements have declined. Here we update this information and include data for the other four targeted clinical areas, where it is available on provincial websites (see Table 1). Taken together, these numbers indicate that wait times have declined for some services in some parts of the country. For example:

- Over the past five years in British Columbia, the median wait time for cataract surgery decreased from about 10 weeks to 7.6 weeks. ("Median wait time" means that, of all the people waiting, half receive their treatment within the time period noted.)
- During July to September 2006 in Newfoundland and Labrador, 98% of patients needing coronary artery bypass surgery had their procedure within 26 weeks (the benchmark agreed to by the provinces and territories), an increase from 95% of patients during April to June that year.

However, this table also makes it clear that governments continue to report wait times in different ways: some report median wait times, some report averages, and others use the percentage of cases completed within a certain time period. Only four provinces report trends. Some governments report wait times for specific procedures, regions or hospitals. The Health Council continues to encourage all jurisdictions to develop wait times information specific to the hospital or facility where the procedure or surgery will occur.

The Canadian Institute for Health Information (CIHI), in a February 2007 update, provided a detailed review of the provinces' public websites (as of December 2006) and also noted that, although each type of information has its strengths and weaknesses, it was not possible to make valid comparisons.[3] Without comparable data—information that is based on similar ways of measuring change—it is not possible to determine on a national level whether meaningful reductions in wait times have been achieved or how many people receive their care within the time frames (benchmarks) agreed to at the end of 2005. Individuals like Frank may not care a great deal about what happens beyond their own province or territory. Except for Northerners, who travel south for much of their specialty care, Canadians do not often receive health care outside of their own jurisdiction. But comparative information is an important tool for the people who manage the jurisdictions' health care systems. They need comparable data to help them evaluate their efforts and to learn from what other

Table 1. Recent wait times and trends for selected procedures, as reported on provincial websites

This table presents wait time information from provincial websites for selected procedures in the five targeted clinical areas (cancer care, heart surgery, diagnostic imaging, joint replacement, and sight restoration), as of the week of June 4–8, 2007. The territories are not included because they deliver few, if any, of these health care services. Instead, arrangements are in place to send patients south to neighbouring provinces.

	Cardiac surgery	**Radiation (cancer)**
Common benchmark* (time within which care should be provided)	**For bypass surgery only, by level of urgency: Level I: 2 weeks, Level II: 6 weeks, Level III: 26 weeks**	**4 weeks from being ready to treat**
British Columbia *www.health.gov.bc.ca/cpa/mediasite/waitlist/median.html*	2001/02–2006/07: median† decreased from 15.1 to 11.3 weeks.	Jan-Mar/07: median 0.9 weeks. No trend reported.
Alberta *www.ahw.gov.ab.ca/waitlist/WaitListPublicHome.jsp*	Apr/06–Feb/07: median for CABG‡ decreased from 3 to 2 weeks.	Feb-Apr/07: median for breast and prostate cancer 3–5 weeks. No trend reported.
Saskatchewan *www.sasksurgery.ca/wait-list-info.htm*	Oct/06–Mar/07: median was 1.3 weeks for all non-emergency cardiac surgery in 10 southern RHAs. No trend reported.	SK Cancer Agency provides treatment services. Wait time data not reported.
Manitoba *www.gov.mb.ca/health/waitlist/*	Apr/07: median ranged from 5 to 31 days depending on urgency level. No trend reported.	Apr/07: median was 1 week. No trend reported.
Ontario *www.waittimes.net*	Sep/05–Mar/07: time to complete 90% of CABG decreased from 49 to 42 days.	2003–2006: median decreased from 6.4 to 4.4 weeks. *www.cancercare.on.ca*
Quebec *http://wpp01.msss.gouv.qc.ca/appl/g74web/default.asp*	Apr/07: % of cases completed within Quebec's guideline of 3 months maximum is reported by facility; e.g. Institut de Cardiologie de Montréal, 80% completed within 3 months. No trend reported.	Mar/07: % of cases starting treatment within 4-week benchmark is reported by region; e.g. in Montreal Region, 88–99% started treatment within 4 weeks. No trend reported.
New Brunswick *www.surgerynewbrunswick.ca/wait-e.asp*	Apr/05–Mar/06: 95.8% completed within 6 months. No trend reported.	Apr/07: 97.6% started treatment within 4 weeks, up from 91% in Feb/07. *www.gnb.ca/0051/cancer/benchmarks_wait-times-e.asp*
Nova Scotia *www.gov.ns.ca/health/waittimes*	Apr/07: average ranged from 3 to 189 days across 4 urgency levels. No trend reported.	Apr/07: average waits reported by region and urgency level; e.g. Cape Breton, average ranged from 0 to 31 days across 4 urgency levels. No trend reported.
Prince Edward Island *www.gov.pe.ca/photos/original/WaitTimes.pdf*	Not applicable. No cardiac surgery in PEI.	2006: median was 11 days. No trend reported.
Newfoundland and Labrador *www.releases.gov.nl.ca/releases/2007/health/0405n06.htm*	Jul-Sep/06: 97.8% of CABG completed within benchmark, up from 95.2% in previous quarter.	Jul-Sep/06: 89% started treatment within 4 weeks, a decrease from 92–100% in previous 3 quarters.

* The provinces and territories announced these pan-Canadian benchmarks on December 12, 2005. Quebec has set its own benchmarks (for details, see the Quebec website noted above).

† Median wait time: Of all people waiting, half received treatment in the time noted.

‡ CABG: coronary artery bypass graft

We present increases or decreases in wait times where provinces report trends on their public websites. Provinces use different measures to report wait times, making it difficult to compare progress across the country or to provide a national picture of progress on wait times.

All provinces report additional information on their websites, and we encourage readers to follow the links below for further information.

Hip replacement **26 weeks**	**Knee replacement** **26 weeks**	**Diagnostic imaging** **Common benchmark not yet available**	**Cataract surgery** **16 weeks for patients at high risk**
2001/02–2006/07: median decreased from 19.6 to 16.4 weeks.	2001/02–2006/07: median decreased from 25.3 to 21 weeks.	Not reported.	2001/02–2006/07: median decreased from 9.9 to 7.6 weeks.
Apr/06–Feb/07: median decreased from 16 to 12 weeks.	Apr/06–Feb/07: median decreased from 22 to ~17 weeks.	Apr/06–Apr/07: for CT, median of 2 weeks did not change; for MRI, median increased from 10 to 11 weeks.	Apr/06–Feb/07: median increased from 12 to ~15 weeks.
Oct/06–Mar/07: median was 20.4 weeks for all non-emergency orthopedic surgery completed in 10 southern RHAs. No trend reported.		Not reported.	Oct/06–Mar/07: median was 5 weeks for all non-emergency eye surgery completed in 10 southern RHAs. No trend reported.
Apr/07: median ranged from 7 to 44 weeks depending on region. No trend reported.	Apr/07: median ranged from 14 to 35 weeks depending on region. No trend reported.	Apr/07: average was 8 weeks for MRI and CT. No trend reported.	Apr/07: median ranged from 4 to 21 weeks depending on region. No trend reported.
Sep/05–Mar/07: time to complete 90% of cases decreased from 351 to 252 days.	Sep/05–Mar/07: time to complete 90% of cases decreased from 440 to 321 days.	Sep/05–Mar/07: for CT, time to complete 90% of cases decreased from 81 to 61 days; for MRI, time to complete 90% decreased from 120 to 108 days.	Sep/05–Mar/07: time to complete 90% of cases decreased from 311 to 159 days.
2005–2006: % of patients treated who waited 6 months or more is reported by hospital and by region; e.g. in Montreal Region, 0–26% completed surgery within 6 months. No trend reported.	2005–2006: % of patients treated who waited 6 months or more is reported by hospital and by region; e.g. in Montreal Region, 0–52% completed surgery within 6 months. No trend reported.	Not reported.	2005–2006: % of patients treated who waited 6 months or more is reported by hospital and by region; e.g. in Montreal Region, 0–8% completed surgery within 6 months. No trend reported.
Apr/05–Mar/06: 66.1% completed within 6 months. No trend reported.	Apr/05–Mar/06: 51.7% completed within 6 months. No trend reported.	Not reported.	Apr/05–Mar/06: 76.9% completed within 6 months. No trend reported.
Oct–Dec/06: 44% completed within 26 weeks. No trend reported.	Oct–Dec/06: 36% completed within 26 weeks. No trend reported.	May/07: for MRI, expected wait ranges from 19 to 109 days; for CT, from 0 to 70 days. No trend reported.	Oct–Dec/06: 34% completed within 30 days; 50% within 60 days; 59% within 90 days; 93% within one year. No trend reported.
2006: median was 11 weeks. No trend reported.	2006: median was 19 weeks. No trend reported.	2006: for CT, median was 8 weeks (routine cases) and within 1 week (urgent); for MRI, median was 12 weeks (routine) and within 48 hrs (urgent). No trend reported.	2006: median was 11 weeks. No trend reported.
Jul–Sep/06: 83.8–100% completed within 26 weeks, depending on region, compared to 88–100% in previous quarter.	Jul–Sep/06: 82.5–100% completed within 26 weeks, depending on region, up from 67–100% in previous quarter.	Not reported.	Jul–Sep/06: 88–100% completed within benchmark, depending on region, up from 85–100% in previous quarter.

jurisdictions are doing. This also enables system managers to assure taxpayers and funders that their investments in improving access to care are wise.

We do know that there has been significant investment and activity to improve access to care, particularly in the five priority areas of care, and some recent reports indicate that these investments have bought increases in the numbers of people who received care in the priorities areas.

CIHI compiled Canada-wide data (excluding Quebec, where data were not available) and found that, with the exception of cancer care, rates for surgery in all of the priority areas increased between 2001/2002 and 2005/2006.[4] The following results are adjusted for population growth and aging:

- Knee replacement surgery rates grew by 53% and hip replacements by 31% over the past five years, an increase of 14,300 more knee surgeries and 6,900 more hip replacements in 2005/2006 than in 2001/2002.
- Cataract surgery rates grew by 18%, resulting in 52,000 more surgeries.
- Cardiac revascularization rates (including bypass surgery and angioplasty) grew by 12%, resulting in 10,700 more procedures performed.

Over the same five-year period, the rate of surgeries outside of the five priority areas of care also grew, even after accounting for changes in the population. Not surprisingly, the increase in surgical volume was greater in the priorities areas overall (7%) than in the non-priority areas (2%). This is an important, but not conclusive, discovery about a concern expressed anecdotally and by the Health Council, most recently in *Health Care Renewal in Canada: Measuring Up?* Has the country's intensive, targeted investments in wait time reduction been detrimental to other services that have not been the focus of activity? The CIHI report does reassure us that surgical volumes in non-priority areas of care did not drop while attention has been focused on hip and knee replacements and other specific areas of care. But it does not tell us whether waiting times for non-priority services have been affected.

A more recent study from Ontario paints a similar picture.[5] This analysis showed that there has been a clear increase in rates of hip and knee replacements and cataract surgeries since the introduction of Ontario's wait time strategy. It also showed that rates for procedures that are not part of the wait time strategy did not decrease significantly. As with the CIHI study, the impact on wait times was not assessed.

In conclusion, the First Ministers' commitments in 2004 have clearly led to focused efforts to reduce wait times within—and, in some jurisdictions, beyond—the five priority areas. But, because of the lack of comprehensive and comparable data, it is not possible to report whether each jurisdiction achieved meaningful reductions in wait times for targeted health care services by March 31, 2007.

SHINING A LIGHT...

Hip and knee surgery in BC: connecting the health care dots

The knee bone's connected to the thigh bone, goes the old song. Careful attention to how things in health care interconnect plays a big part in the success of Vancouver Coastal Health region in improving access to total joint replacement surgery to fix aging hips and knees.

The need for action was clear: with the area's population aging, the demand for hip and knee replacement surgery was projected in 2003 to grow by 60% in the next decade, and patients were already waiting too long. Waits in the region ranged from nine to 21 months, yet research shows that patients who need a hip or knee replacement do better—they can walk with less pain and have a better quality of life—if they complete their surgery within six months of the decision to operate, compared to patients who get their surgery after longer waits.

Connecting her business background with many years of work in health care management, Cindy Roberts was co-lead, with orthopedic surgeon Ken Hughes, in the Richmond Health Services Hip & Knee Reconstruction Project, an initiative that began in 2004 at a community hospital in Richmond, BC. From the outset, Roberts explains, the project's goal was to implement and evaluate "a high-quality, high-volume, low-cost" model of service delivery guided by research showing what works best to ensure patients get safe and appropriate care.

A central theme of their approach was to involve people from every aspect of care on a variety of project teams that examined how to make the entire patient journey more efficient. "We considered all the potential impacts," Roberts says, adding that "the health and safety of patients and staff was always our first priority." Teams included not only nurses, physicians, and the people who schedule operating room time and manage hospital beds, but also the staff who see patients before they come for surgery, admit them into hospital, sterilize the surgical equipment, and wheel the gurneys—and that's to name only a few. "Even people in health records, who never see the patients, are important to involve, if you really want to realize these efficiencies," says Roberts.

And the project's focus on connections did not stop at the hospital doors. Back home after surgery, patients need community services while they recover, typically home care and equipment such as crutches, walkers, and bath seats. If Richmond was going to rapidly increase the number of people requiring these services, the project needed to involve the organizations that provide them. "For example, we worked with the Red Cross, which rents and loans mobility equipment, to make sure they had the appropriate resources," Roberts explains. "If patients don't have the equipment they need, we can't discharge them home."

By January 2006, the project had achieved:

- A 136% increase in the number of hip and knee replacement surgeries completed, from 275 cases per year to 675 cases per year;
- A 25% reduction in length of stay in hospital, so that patients were able to go home in four days after hip surgery, and three days following a knee replacement;
- A 25% improvement in operating room efficiency, with the result that one day each week, the hospital could perform eight total joint replacements, compared to just three per day before the project began; and
- A 75% reduction in wait times for joint replacement surgery: the average wait declined to five months, from 20 months at the start of the project.

The changes created through the project are now standard procedure at Richmond Hospital, and wait times have continued to improve: the median wait is now less than four months, with more than 70% of cases completed within the national benchmark of six months.

To help other hospitals adopt this model of change, Cindy Roberts and Ken Hughes created a how-it-was-done toolkit called "The Arthroplasty Plan." The kit contains details and templates on the make-up of various committees and task groups, patient education materials, consent forms, clinical records, evaluation tools, and the role of everyone from admitting to cleaning. More than 100 copies of the toolkit have been distributed throughout BC, across Canada, and in the UK. "One size doesn't fit all, but we think the model is adaptable," Roberts says. "The fact that we were able to achieve these things in a community hospital, rather than a larger hospital, where you have dedicated orthopedic teams and units, is an important piece."

Roberts is now bringing her sense of connection to a new role as Implementation Director of OASIS (Osteoarthritis Service Integration System), another innovative project in Vancouver Coastal Health region. OASIS provides a central assessment and triage service for people with osteoarthritis—from their first diagnosis through to more acute stages of the disease—linking local services with primary care physicians and their patients. The idea is to bridge some important gaps in the current system of care. OASIS connects patients to education and services such as pain management, physical therapy, and counselling on diet and exercise, so that patients can better manage their conditions and be ready for surgery if it is required, or possibly postpone their need for it. A new website is one of the OASIS resources: *www.vch.ca/oasis*.

WAIT TIME GUARANTEES: WHAT WILL THEY CHANGE?

In early 2007, the federal government promised additional health care funding for jurisdictions interested in establishing a wait time guarantee in one of the priority areas. The federal budget released on March 19 established a Patient Wait Times Guarantee Trust. Here's what the Budget Plan said:

> *To support jurisdictions that made commitments to patient wait times guarantees prior to the end of March 2007, Budget 2007 sets aside up to $612 million to be used to help accelerate the implementation of patient wait times guarantees. $500 million will be allocated on an equal per capita basis, and funding for eligible provinces and territories will be paid into a third-party trust. Those eligible provinces and territories will also be provided base funding of $10 million per province and $4 million per territory through the trust to move forward with patient wait times guarantees. This funding will be available to those provinces and territories that have publicly outlined their plans to implement a patient wait times guarantee in at least one of the five priority areas where evidence-based benchmarks for medically acceptable wait times are being developed ... A one-time patient wait times guarantee pilot project fund of $30 million, to be spent over three years, will be established by Health Canada to assist provinces and territories in undertaking innovative projects that will support the implementation of their patient wait times guarantees.*

By mid-April, all jurisdictions had agreed to a "care guarantee" in exchange for this funding. Table 2 outlines the guarantees agreed to by each province and territory and their timelines to implement them. Six jurisdictions will implement a guarantee for radiation therapy, two for cardiac surgery, and one each for cataract surgery, mammography, diagnostic imaging, and primary health care. These are in addition to care guarantees previously announced by Quebec for cataract, hip and knee surgeries. The federal government is also implementing care guarantees in areas of health care that fall within its purview: late in 2006, Health Canada announced that it would run pilot projects to evaluate wait time guarantees related to diabetes and prenatal care for First Nations communities, where health care is a federal responsibility.

Wait time guarantees in Canada are too new to determine what impact they will have on the health services provided to Canadians. Here the Health Council explores some of the questions Canadians may have about wait time guarantees, such as:

- What is a wait time *guarantee*? How does it differ from a wait time *target* or a wait time *benchmark*?
- Has my jurisdiction made any wait time guarantees based on this new funding? (See Table 2)
- How will these wait time guarantees be implemented?
- Do other countries have wait time guarantees and what can Canadians learn from them?

Benchmarks, targets, and guarantees: what's the difference?

Benchmark: A wait time benchmark refers to a maximum wait time that is recommended by experts to be medically acceptable for specific procedures. Benchmarks represent objectives that jurisdictions will strive to meet toward the goal of timely and appropriate health care. They are not intended to be a guarantee or legal obligation. Instead, a benchmark declares a time period (measured in days, weeks or months) within which most patients will be treated. For example, the current pan-Canadian benchmark for hip replacements is 26 weeks.

Target: A target is the expected or desired percentage of cases that should be completed within the time specified by the benchmark. For example, a province could set a target that 90% of hip replacements will be completed within the 26-week benchmark. Each province and territory has agreed to set targets to achieve the benchmarks in the priority clinical areas by December 31, 2007.

Guarantee: Unlike benchmarks and targets—which define what percentage of cases within a population of patients will be completed in a certain time frame—a guarantee can be understood to apply to all individual cases. A guarantee implies that 100% of cases will be completed within an agreed-upon time frame and, if that time frame is exceeded, there is recourse available to individual patients to ensure they receive timely treatment.

What is a wait time guarantee?

The term *guarantee* was not used in the 2004 10-year plan, which instead referred to *benchmarks* and *targets*. How do these terms differ? While different governments use the term differently, a *benchmark* generally refers to a recommended maximum wait time, and a *target* refers to the percentage of patients who should be treated or served within that period of time.[6] A *guarantee*, on the other hand, speaks to the individual case and indicates a time period in which all patients should receive needed health care before some kind of alternative action or recourse is available to them.

What does this mean for people like Frank who wait for health care?
In Frank's case, his 12-month wait for hip replacement surgery, finally completed in early 2006, far exceeded the six-month benchmark that the provinces and territories had agreed to at the end of 2005. Despite the fact that Frank waited longer than the benchmark, there was little he could do except to stay in touch with his surgeon's office and ask about his place on the waiting list. However, if a wait time guarantee had been established where Frank was living, he theoretically would have had options to consider in order to have his surgery done without further waiting.

Do patients in other countries have wait time guarantees?

The idea of mandating time frames for access to health care is not unique to Canada. Other countries have developed various forms of care guarantees in an effort to improve access and reduce wait times for health care procedures. In some cases, these policies set out maximum wait times and options for patients who have to wait longer. In other cases, these policies are

national standards or guidelines that describe the goals of timely care but do not actually guarantee that care be provided within a specific time frame. Here is a sample of approaches being taken in other countries that, like Canada, have publicly funded health care systems.

United Kingdom: The National Health Service (NHS) is working towards the goal that, by the end of 2008, no patient will have to wait longer than 18 weeks from referral by a primary health care physician to the start of treatment, including all tests and outpatient consultations.[7] The origins of this standard can be traced to the 2000 policy report, *NHS Plan: A Plan for Investment, A Plan for Reform*.[8]

Sweden: Beginning in 2005, Sweden's "0-7-90-90" guarantee requires that all medically indicated and scheduled treatment must be provided within three months, from the time of the decision for treatment.[9] ("0" means same day contact with the health care system; "7" means patients will see a family doctor within seven days; the first "90" means consulting a specialist within 90 days; the second "90" means waiting no more than 90 days from diagnosis to begin treatment.) Patients who cannot be treated within three months are offered care at another hospital in their health services district, in another district, or through private providers. In any case, the cost of services is publicly funded. This care guarantee evolved from a 1992 plan to provide a similar three-month maximum wait for the 12 most common diagnoses for non-urgent surgery.

Finland: Legislation in Finland sets out a "three days, three weeks, three months" time frame for patients to be examined and treated at primary health care centres and hospitals. Patients must be assessed within three days of their first contact about a health problem. Further assessment by a specialist, if required, must be arranged within three weeks, and if the specialist recommends treatment, this care should be provided within three months and no later than six months. If a local facility is unable to meet these time frames, treatment must be provided through another service at no extra cost to the patient. Similar to other Scandinavian countries, Finland's comprehensive approach to wait time guarantees includes non-surgical services such as mental health treatment for children and young adults, and dental care.[10]

Denmark: If their wait time for treatment goes beyond two months, patients in Denmark have the right to choose to go to another Danish public hospital or to a private hospital or clinic in Denmark or abroad that has a service agreement with the patient's regional health authority. This policy has been in place since 2002, and the accepted waiting time for treatment will be reduced to one month as of October 2007.[11]

Australia: Australia has developed a national standard for access to surgery that calls for each patient to be assessed by a specialist and assigned to one of three priority groups: Category 1 (patient requires treatment within 30 days), Category 2 (patient requires treatment within 90 days), Category 3 (patient requires treatment at some time in the future).[12] National policy does not guarantee care within these time frames, but state, territory and national governments report on the percentage of patients who complete their surgery within their recommended wait time.

New Zealand: New Zealand has also established national standards for access to care.[13] Unlike Australia's standards, which cover only surgery, New Zealand's policy is comprehensive and specifies how patients should be managed while waiting for any elective or non-urgent health care service. A system of priority scoring assists primary care and specialist physicians to assign patients to one of several urgency groups. If a patient's need for treatment does not meet a certain level of urgency, treatment in the public health care system is not assured. The national standard states that patients who meet the urgency threshold for publicly funded care should receive service within six months, and for those below the threshold, their health status should be reviewed every six months.

It is difficult to say what Canada might learn from international experience because few of these programs have been well evaluated. And what works in one country may not be transportable to another. Have any or all of these approaches successfully reduced wait times without hurting other areas of health care? More research is needed to answer that question.

How will wait time guarantees be implemented in Canada?

Although the term guarantee implies that individuals will have recourse if their wait for a particular service exceeds a set time, to our knowledge only Quebec (which established care guarantees for hip, knee and cataract surgery in 2006) has publicly acknowledged such a process of recourse. Except for Ontario, none of the jurisdictions that signed on in response to the federal budget has even discussed in theory how a person might go about invoking the guarantee. This may be for good reason; experience in other countries has shown that providing such recourse is logistically difficult, costly, and not necessarily acceptable to all parties.

In April, after Ontario agreed to implement a care guarantee for cataract surgery, the provincial Wait Time Strategy office published a set of "guiding principles that are being considered" to guide the province's wait time guarantee for cataract surgery.[14] Patients who are approaching the benchmark for cataract surgery of 182 days would have the option to voluntarily enter the "guarantee program" by phoning a toll-free number. The "guarantee office" would intervene to ensure the patient receives the surgery, preferably at his or her hospital or, failing that, at another Ontario institution within the public health care system. In contrast, Quebec will pay for treatment at a private clinic if public hospitals cannot serve patients within six months. Details of Ontario's proposal are available in the "Wait Times Update – April 30, 2007" available at *www.waittimes.net* (go to "Health Care Professionals," then "The Wait Time Strategy"). For more information on Ontario's strategy to reduce wait times for cataract surgery, please see our story, page 28.

Table 2. Wait time guarantees by jurisdiction

In March and April of this year, each province and territory announced that it would implement a wait time guarantee, in response to the March 19 federal budget. (Quebec is the exception: it began implementing wait time guarantees in 2006). As these are recent announcements, few details are publicly available. The table below compiles information from government news releases and websites.

Each government has identified a specific clinical service and maximum wait time after which the guarantee will apply. For current wait times, each government reports differently, making it difficult to compare performance across jurisdictions, and in some cases making it difficult to know how close the jurisdiction may be to meeting the maximum wait time promised in the guarantee.

Province / territory	Funding from 2007 federal budget*	Clinical service	Maximum wait time	In place by	Current wait times (based on public reporting as of June 4, 2007) †
British Columbia	$76.4 million	Radiation therapy	8 weeks from ready to treat	March 31, 2010	5 out of 10 cases start treatment in 6 days (median) (for Jan-Mar/07)
Alberta	$62 million	Radiation therapy	8 weeks	2010	5 out of 10 cases start treatment in 3 to 5 weeks, depending on location (for Feb-Apr/07)
Saskatchewan	$24.8 million	Coronary artery bypass graft surgery	2 to 26 weeks, depending on the level of urgency	2010	78% performed within 3 weeks. All remaining performed within 12 months (for Jul–Dec/06)
Manitoba	$27.9 million	Radiation therapy	4 weeks	Spring 2008	5 out of 10 cases start treatment in less than 1 week (for Apr/07)
Ontario	$205 million	Cataract surgery	26 weeks	January 1, 2009	9 out of 10 patients treated within 159 days (for Feb–Mar/07)
Quebec	$127 million	Hip and knee replacement Cataract surgeries	6 months	Currently in place	% who waited 6 months or more: for hip replacement 7%, for knee replacement 13%, and cataract surgeries 3% (2005/06)
New Brunswick	$21.3 million	Radiation therapy	8 weeks	2010	97.6% start treatment within 4 weeks (Apr/07)
Nova Scotia	$24.2 million	Radiation therapy	8 weeks	2010	Average for Priority 4 (least urgent) patients: 31 days (Cape Breton) and 37 days (Capital Health) (Apr/07).

Province / territory	Funding from 2007 federal budget[1]	Clinical service	Maximum wait time	In place by	Current wait times (based on public reporting as of June 4, 2007)[2]
Prince Edward Island	$12.1 million	Radiation therapy	8 weeks from ready to treat	March 31, 2010	5 out of 10 cases start treatment in 11 days (median) (Jan–Dec 06)
Newfoundland & Labrador	$18 million	Cardiac surgery	26 weeks	March 2010	97.8% of cases completed within 26 weeks (Jul–Sep/06)
Yukon	$4.5 million	Mammography	Not available	February 2010	No information available
Northwest Territories	$4.6 million	Primary health care	Not available	March 2010	No information available
Nunavut	$4.5 million	Some types of diagnostic imaging	Not available	2010	No information available
Federal government	The Government of Canada announced, in late 2006 and early 2007, that it would initiate a series of pilot projects to evaluate wait time guarantees for prenatal and diabetes care in selected First Nations communities. Prenatal • initial prenatal appointment within 2 weeks of positive pregnancy test; • appointments scheduled with a health care provider every 4 weeks after initial visit; • confirmation of a future appointment for specialist and diagnostic services made within 2 weeks of decision to refer a woman with an at-risk pregnancy. Diabetes • adults who test positive for diabetes will have an appointment within 2 months for an assessment and diabetes education with a primary health care provider on reserve; • adults who test positive for "pre diabetes," or early diabetes, will be given the opportunity to participate in a diabetes prevention, education and support program within 3 months; • adults who have a normal test result will be retested within 1 year; • a pilot project to test a defined time frame for diabetic foot ulcer care.				

Notes:

* In addition to the funding noted, provinces and territories will also be eligible for a portion of the $400 million in funding for Canada Health Infoway and the $30 million for pilot projects announced in the 2007 federal budget.

† This column contains information about the current wait time for the clinical service subject to each jurisdiction's guarantee. More detailed wait times data are available on government websites.

SHINING A LIGHT...

Diagnostic imaging in Saskatchewan: learning from success in surgery

When Saskatchewan set out to wrestle with problems around patients' access to diagnostic imaging—MRI, CT, and bone density scans—the province looked naturally to its own success in managing wait times for surgery. The basic issues were similar: there was no systematic way of knowing how long patients were waiting or whether those waits were clinically acceptable or too long. There was no overarching structure to shepherd change. In addition, the province needed to face the expensive job of replacing old imaging equipment.

Fashioned after the Saskatchewan Surgical Care Network (SSCN), the two-year-old Diagnostic Imaging (DI) Network is the first of its kind in Canada. As with surgery, the DI Network provides a forum for government, the province's 12 health regions, expert clinical specialists (in this case, radiologists), and a public representative to create collectively a more focused, organized approach to services. (SSCN is profiled in a Health Council of Canada video, available at *www.healthcouncilcanada.ca*.)

Peter Glynn, who chairs the DI Network as he did the SSCN, and Doug Calder, Director of Saskatchewan Health's Acute and Emergency Services Branch, reel off the lessons learned from the province's experience with the Surgical Care Network:

- Leadership and a vision are essential ingredients; so is a real commitment to change. "This is not a project," notes Glynn. "It's a permanent way of reorganizing the system."
- Staff must be assigned to support the network and given the time to do the job. "If you try to do it off the corner of someone's desk," Glynn says, "it doesn't happen fast enough or smart enough."
- Information—undisputed data to describe the problems and the impact of solutions—fuels the network's ability to secure the necessary resources. In other words, when ministers have the facts, it's easier for them to advocate for funding.
- Getting everyone to agree on common terms and concepts—to get people "singing from the same song sheet"—is a critical early step, Calder notes. "It means people can focus on the issues, instead of wasting energy arguing about whose facts are right." When, for example, does a wait time start? How are patients classified by the urgency of their need for care? These common definitions underpin an information system that allows the public, health care providers, and health care managers to compare data across the province's regions and to see what's happening province-wide.
- The job of managing patient wait lists now lies with the health regions, not with individual physicians' offices, as it was in the old model of care across Canada. That shift in accountability is key, Glynn stresses. "You can't manage access if you don't know the patient's name," he says.

Putting this knowledge into action, Saskatchewan has begun to bring down wait times for diagnostic imaging, even while demand for services has grown. For example, between March and December 2006:

- Maximum wait times for elective (non-urgent) CT scans declined to between eight and 90 days, depending on the health region, compared to the longest waits of 196 days in March;
- Maximum wait times for elective MRI scans decreased by 70% in Regina (to up to 90 days) and 14% in Saskatoon (up to 180 days);
- For bone mineral density scans, wait times dropped by 23% in Regina and 31% in Saskatoon, despite a 17% increase in referrals.

Collaborating on the purchase of new equipment has been important to this progress. Health regions reaped savings of more than $300,000 in 2005/2006 through bulk purchasing to upgrade machinery, and they have put that money back into further capital investments.

Ensuring that referrals for diagnostic imaging are appropriate is another focus of the network's work. "Frankly, I don't like the term 'wait time,'" Glynn says. "The more important issue is: are we getting the right test to the right people in a timely way?" Research suggests that unnecessary testing could account for as much as 10–20% of patient waits, as well as needlessly exposing patients to radiation, Glynn notes. The DI Network is pilot-testing an electronic tool to help physicians apply referral guidelines developed by the Canadian Association of Radiologists. Eventually, this decision-support tool will be integrated with an electronic order-entry system that will be able to show doctors their patterns in ordering tests.

The launch of a public information website is planned for this year. As with the website of the Surgical Care Network (*www.sasksurgery.ca)*, patients will be able to check wait times for diagnostic imaging in each region and to suggest to their referring physician that they could go elsewhere for their test. With the introduction of electronic systems to store and transmit diagnostic images anywhere in the province, physicians will soon have access to their patients' test results no matter where the scan was done. Several provinces are moving towards adopting these digital imaging systems, with the support of Canada Health Infoway. Saskatchewan is scheduled to have its system in place province-wide by the end of 2009.

WHERE DO WE GO FROM HERE?

At the end of the day, what likely matters most to Canadians about wait time guarantees is the impact that they will have on the care they receive. What options will individuals have if their waits are longer than guaranteed? Will other areas of care, those not covered by the guarantees, be affected? It is too early to answer these and the many other questions that arise with Canada's introduction to the concept of guarantees. Indeed, without the appropriate data, important questions about the impact of guarantees may never be answered. The Health Council is hopeful that in the months and years ahead the jurisdictions will establish the necessary infrastructure to allow them to evaluate their strengths in providing these guarantees and to adjust their courses of action based on solid data collected along the way.

Ideally, the best guarantee is one that rarely, if ever, needs to be invoked. At this point, the provinces have chosen a safe approach to accepting the federal proposal; they have chosen to implement guarantees for services that they are already, or are well on their way to, delivering within the guaranteed time frame (see Table 2).

If wait time guarantees create incentives that support the goals of reducing wait times and achieving established benchmarks, they may play a valuable role in resolving Canada's wait time problem. However, unless access improves for health care services not subject to the guarantees, the guarantees by themselves may fall short of meeting the expectations of Canadians.

The Council has commended governments for their efforts to share information with the public on the waits that they face for care[15] and we note that work on public websites is ongoing. The Council has previously offered advice on improving the quality—and therefore the usefulness—of wait time information, particularly to ensure that data can be compared across jurisdictions.[16] Governments continue to invest in ways to reduce their wait times for care: the recent funding announcements around guarantees are just part of the picture. The Council believes these investments must also result in reliable, comparable data so that patients, clinicians, managers and administrators at all levels can understand and evaluate the effectiveness of the changes that this funding has purchased.

SHINING A LIGHT...

Cataract surgery in Ontario: a vision for change

In the story of Ontario's success in reducing wait times for cataract surgery, various kinds of numbers play important roles. But in human terms, says Alan Hudson, a physician who leads Ontario's Wait Times Strategy, the story is simple: "Thousands of people who couldn't read or drive now can."

In less than two years and despite increasing demand, the time that most patients wait for cataract surgery has been cut in half—from a high of 311 days in August/September 2005 down to 159 days in the most recent reporting cycle (February/March 2007). That's a 49% reduction and, to use Ontario's own wait times language, means that nine out 10 cataract surgeries are completed ahead of the province's target of 182 days.

How was it done? By increasing capacity and by using "money and data" to convince people to do things differently, says Hudson. Ontario created several free-standing cataract clinics and merged services across several hospitals in order to move more patients through surgery more quickly. With cataract surgery—a procedure that removes a clouded lens and replaces it with an artificial one—most surgeries are not urgent or complicated. High-volume facilities can meet much of that demand safely. One such centre in Toronto, the independent, not-for-profit Kensington Eye Institute, was created to serve the wait times strategy.

To help motivate facilities to increase their volume of surgeries, Ontario "introduced market forces" into service planning, Hudson explains. Individual hospitals sign contracts with the province to provide a certain number of cataract procedures; this is funding on top of their global budgets. The province asked: How many additional cataract surgeries do you want to do at $750 apiece? "By intent, we set the price high," Hudson explains, "and we've lowered the price year by year. We expect it will get down to about $400."

"Team anesthesia" is also helping surgery centres make more efficient use of their facilities, not only for cataracts but for other types of surgery as well. Instead of requiring an anesthetist to be present in the operating room for uncomplicated procedures, team anesthesia means that a specially-trained nurse can attend the surgery, with the physician on standby in the building. Expert panels, made up of clinical specialists respected by their peers, act as independent advisors to government and play a critical role in easing the way through changes in practice such as team anesthesia.

Although pleased with the progress in cataract wait times, Hudson does not hesitate to point out the road ahead, for example the disparities among Local Health Integration Networks (LHINs), Ontario's new regional health care planning entities. "The spreads are still too big between the best and worst LHINs," he notes. (As of late May, data on the government wait times website *www.ontariowaittimes.com* showed a range of very long waits of more than 1.5 *years* [559 days] to the shortest waits of 65 days, although most LHINs fell close to the

provincial average of 159 days.) Whether most patients who are referred for cataract surgery are appropriate for the procedure (that is, can they be expected to benefit from it?), and how many actually have improved sight afterwards, are important questions that expert panels are working on, Hudson says.

Hudson concludes that a number of "touchstones" are common to success in reducing wait times, regardless of the service area: political will, information technology, funding, accountability ("Who's in charge? It used to be the answer was 'no one,'" Hudson says), and transparency. Transparency is the job of the wait times website. To maintain public confidence in the website, the province recently established a Data Certification Council to verify wait times data every two months.

Reflecting on the landscape today compared to three years ago, when the Wait Times Strategy began, Hudson calls it a "chalk and cheese" difference. "I spent my entire life in surgery and only my secretary knew my wait list. Today, hospitals are accountable and we have a website where anyone can see—at home or in a library—wait times in their postal code area. The whole point is to empower patients."

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Canada's First Ministers established the Health Council of Canada in the 2003 *Accord on Health Care Renewal* and enhanced our role in the 2004 *10-Year Plan to Strengthen Health Care*. We report on the progress of health care renewal, on the health status of Canadians, and on the health outcomes of our system. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors with expertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government.

Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

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An informed and healthy Canadian public, confident in the effectiveness, sustainability and capacity of the Canadian health care system to promote their health and meet their health care needs.

The Council's mission

The Health Council of Canada fosters accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system. Through insightful monitoring, public reporting and facilitating informed discussion, the Council shines a light on what helps or hinders health care renewal and the well-being of Canadians.

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