Managing Wait Times in Saskatchewan
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1) Introduction

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

surgical procedures[2] and provide physicians with a series of protocols for the standardized assessment of patients by physicians and the allocation of surgical time by hospitals. As the SSCN evolved it incorporated benchmarks for wait times for categorized surgical or diagnostic procedures, patients can see where they are on the list but must contact the surgical coordinator for their health district who will give a reasonably firm estimate of how long they may be waiting for a procedure given their specific degree of severity. As is evident below, the eventual rolling out of the SSCN in July, 2003 was the culmination of a number of previous interventions (both successful and unsuccessful) to manage wait lists and reduce wait times in the province.

Data was collected from a series of twelve interviews including members of the civil service, physicians, academic researchers, employees/managers from Regional Health Authorities (RHAs), elected officials and representatives of stakeholder organizations. While all those interviewed were familiar with the evolution of the SSCN, a number of the people interviewed were particularly central to the SSCN‟s creation and had been heavily involved in the wait list policy reform process before the SSCN. The remainder of the participants were involved at various stages in the wait list policy reform process.

Saskatchewan‟s experience with wait list management clearly demonstrates first a series of more or less “one off” attempts to deal with a politically sensitive issue and, second, a more focussed, almost evolutionary, approach designed to build on past successes, learn from other jurisdictions and accumulate increasingly more sophisticated evidence to guide decision making. The SSCN evolved out of a decade of various

[2] The surgical procedures included Cardiovascular, Dental, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedic, Otolaryngology, Plastic and Reconstructives, and Urology, as well as General Surgery which covers other forms of non-specific surgery.

federal, provincial and external reports; unsuccessful policy and negative media coverage which all showed long surgical waiting times to be a significant problem within the health system. The government of Saskatchewan learned from its and other jurisdictions' experiences and from research to create policies surrounding waiting lists. At each step fundamental learning took place that allowed the next policy to better suit the unique needs of the province.

The SSCN is "an advisory committee to Saskatchewan Health dedicated to creating a more reasonable [and] fair surgical system for all Saskatchewan people."[3] The network is responsible for providing advice to Saskatchewan Health on three points: the planning and management of surgical services in Saskatchewan, the development of standards and monitoring performance, and communicating with the public and health providers on surgical access issues.

The network also sponsors a website that "provides general information about how many specialists there are in each of the health regions to do specific types of procedures. It also lists their credentials to help patients make informed decisions."[4] More recently, the network has developed a patient assessment process which includes six prioritization levels with corresponding target wait times for each. Patients are prioritized as their surgeon sees them by being rated by point-count measures according to level of pain, the potential of the condition to worsen and the ability of the patient to func includes BT1 0 03f0 1 9kthe lso slpt ofme(e)4etal (s)] TJ mecn n0(tar4(ti)bk)3( )s oo-8((g)10(ove(h. -

target time frame for Priority I patients (95-100 points) is to have ninety-five percent of surgeries done within twenty-four hours. On the opposite end of the scale, the target time frame for Priority VI patients (1-29 points), is to have eighty percent of the surgeries completed within twelve months, with all surgical procedures (Priorities I through VI) to be completed within eighteen months.

The SSCN also serves as an aide for case management. For example, prior to the launch of the SSCN, a surgeon might, on occasion, forget to submit a booking slip for surgery. In such a case, the patient might not realize that the surgery had not yet been booked until they checked on their expected wait with the specific hospital that would be doing the surgery. Although such occurrences are, in all likelihood, rare, they are not unknown the result would be an even greater delay in getting surgery insofar as the patients "real" wait does not begin until such time as the surgery is actually booked.

The protocols within the SSCN make this much less likely to occur and are designed to insure that patients get information concerning their surgery shortly after it is booked by the surgeon. As one senior official put it:

> So this way you should actually get a confirmation slip for wherever you're going to get surgery saying we've received it…So you should be able to go to the website or your brochures that say you should expect this…and we'll eventually build on that to say your urgency level etc. But it's just linking the pieces of the system so that the patient actually gets through in a timely and expected [manner]."[5]

However, the patient has to actually know to expect a confirmation of their surgery booking in order for the process to work properly which, in part, has been a focus of government informational campaigns that accompanied the launch of the SSCN website.

[5] 12WLSK

Taking what was heard from the interviews, it is possible to identify a number of key policy goals at the heart of the decision to create the Surgical Care Network. In short the government of Saskatchewan was trying to achieve consistency, transparency, confidence and fairness with the SSCN. Consistency allows for comparable data between Regina and Saskatoon, for example, whereas before it was difficult to get comparable data for each city, and as the case with Royal University Hospital in Saskatoon – each hospital would have different ways of organizing waiting lists. A transparent process allows for the public to see exactly how long they can expect to wait. "One of the concerns (of government) was that often times people don't understand how the system works, where they are on the list, why there are others ahead of them [and] why there are some behind them."[6]

This ties in very closely to confidence as government could not say with confidence that "the people that are on the waiting list today and the priority within those waiting lists is based of the need of that person's illness. And the people that need it the most are getting access to procedures first."[7] Achieving consistent, transparency and confidence would "increase the perception of fairness" as patients would know where and why they are on the waiting list.

While consistency, transparency, confidence and fairness are easily understandable, they are also largely intangible and non-specific. One of our participants closely tied to an RHA identified five key, more measurable, goals that outline what government was seeking to achieve. The first goal was to insure that the information provided by the SSCN was as accurate as possible both for individual members of the

[6] 03WLSK
[7] 01WLSK

surgical care system‟s ability to predict who needs surgery, and the time frame within which it should be done. *This will promote the best possible use of resources and system capacity, and will ultimately result in reduced waiting times for patients."*(Emphasis

participants in this study: physicians, civil servants, RHA staff, elected officials and researchers – mentioned analytical reports as an important step in the policy process. The most often cited report by participants is the annual release of a methodologically suspect report from the conservative think tank the Fraser Institute that consistently painted a

minds."[17] And "without a doubt government sits down and says…Fraser's coming out, we would like to have some accurate information before Fraser comes out."[18] This was seen as a challenge by the RHAs; their "frustration was largely driven by the fact that…when you try and explain this kind of complicated thing to the media, eventually they just get this starry-eyed look in their face, and generally misquote you, misreport you, don't understand what you're trying to say and it doesn't get you anywhere."[19] Fraser was thus important in one sense because it kept the issue in the forefront of the public mind.

It is worth noting that the impact of the Fraser Institute report on the wait list debate continues despite more accurate data now being available. But at the same time, governments like that in Saskatchewan feel much better prepared to counter the annual release of the Fraser study because they have increasingly accurate data that is more easily presented to the public and the media.

people on the list, those kind of things. It was basically a literature review and analysis

objective measurement of urgency which can be compared between patients with fairly similar conditions."[24]

The task team included Dr. Stewart McMillan; Dr. Barry Maber, Vice President of Physicians at the Saskatoon Health District; and Dr. Mark Ogrady, Head of Surgery

addressed. A few smaller changes were made, many surgeries were moved to day surgery or ambulatory care. However, Government's largest answer to the Task Team's recommendations (and perhaps the largest mistake on the road to waiting list policy reform) was the twelve million dollar wait list initiative announced on March 26, 1999 in the 1999 – 2000 health budget. Many of our participants characterized the physician perspective on the problem with waiting lists to be a resource issue. On more than one occasion, interviewees pointed to the creation of this fund as an attempt by the government to spend their way out of a problem with wait lists – an approach consistent with the perspective of many doctors at the time that defined the problem as a shortage of resources. Essentially the fund transferred in the 1999 – 2000 budget, one time monies to the health districts in Regina and Saskatoon (with Prince Albert and Moose Jaw being added later) with the idea that such a cash infusion would increase capacity and thus decrease surgical waiting lists.

However, "throwing the money at it…didn't create the solution [government was] looking for."[29] According to one participant active in the research community, the thinking behind such a program was that by buying our way out, waiting lists would disappear in a matter of a few years.[30] As became evident in the years that followed, the strategy had little long term impact on the overall size of the wait lists in the districts receiving the funds or on the median wait times within those districts. "What ended up happening is when it came time for the wait list initiative and they started buying volume, what they didn't do is they didn't havi.]4(ric)5(h(onsi)-2(ste3t4 322.))-9e13g49m 0 1 165.74 322.73 Tm[a56 l

just basically suck it up."[31] In other words, the money poured into districts to buy more surgical capacity was not necessarily being used for that purpose.[32]

Although the fund had the effect of giving the public the impression that action was being taken on wait list issues, it was only part of the overall strategy eventually adopted by the government. More important and, in the view of many of the interviewees, more effective was the decision of the government to get involved in the Western Canada Waiting List Project (WCWL) which focused on a managerial approach to long waiting times. "The WCWL started before the provinces were really interested in this issue. The provinces came in later after the start…the start of the public policy issue which was taken up by the scientific and research community and then government finally came in later on."[33] "The WCWL project designed tools for the purpose of…[creating] objective measurement of urgency which can be compared between patients with fairly similar conditions. The final report, submitted on May 1, 2001, recommended that priority criteria be used when deciding where to place a patient on a waiting list.

Some participants in our study thought the Western Canada Wait List priority criteria tools were extremely important for policy development in Saskatchewan. Though there were some who were not pleased with the resulting priority criteria tools, that is not to say they were opposed to the WCWL.

> It has been kind of an interesting mix of a few enthusiasts and a lot of skepticism. The enthusiasts I think inherently recognize that as a surgeon when you're assessing any patient for surgery, implicitly you're going though the same kinds of questions that are on the tools. I mean the

[31] 04WLSK.
[32] Ibid.
[33] 02WLSK

questions and the methodology are not…r' stno я'

similar to the process administered by surgeons already: "when I looked at the Western Canada Wait List tools, I don't think that they differentiate people very well. When you look at the standard…shaped distributions what you do is you get the high end and the low end but the rest are all still chronological and that's probably 90 per cent in the middle."[36]

However, it was an elected official that expressed the most significant reservations about the tools. In short the official felt that while the tools were useful on the front end: "It wasn't dealing with certain medical procedures, the surgical procedures and protocols around that but it wasn't dealing with the overall questions of how do we begin to deal with wait lists and wait times."[37] So while there may not have been much in terms of opposition to the Saskatchewan government's involvement in the WCWL, it was recognized that the tools were far from being a panacea in and of themselves.

It should be noted, in fairness to the WCWL, that the tools were never meant to be „the solution" to wait lists, but rather simply a vehicle to standardize patient assessment and bring a greater degree of consistency to the process by which patients are put on wait lists and a more transparent indicator of why they are in a specific place on the list. It may well be that the cautious approach to the WCWL assessment tools is reflective of a desire on the part of both the physician and the elected official to not repeat mistakes of the past whereby particular policy levers (such as the one-time money to health districts) are seized upon by actors as simple solutions to what are increasingly understood to be complex – perhaps even „wicked" – problems.

Despite a general consensus that the work of the WCWL was important on a number of fronts, there was less consistent agreement on the overall impact that this work had on government policy and in shaping government thinking. Indeed, some participants were indifferent to the impact that the WCWL has had on wait list policy in the province. In the words of one, the government:

> wanted the problem to go away as a public issue. And I say that because some of the ways they moved on the issue indicated that … although they were tied to the Western Canada Wait List Project, and although they sponsored HSURC they moved relatively independently of both organizations. And Western Canada Wait Lists in particular had to sort of struggle to keep up to what Saskatchewan was…planning to do because WCWL had a plan for evaluating the implementation of wait lists management and Saskatchewan was jumping the gun.[38]

However, the WCWL tools provided "opportunities for assessing patients and ranking them, it was exactly in line with where the province wanted to head"[39] with a waiting list management scheme and is not dissimilar to what was implemented through the SSCN.

Despite the public and political attention paid to wait list issues in the province, it is worth noting that the province‟s Commission on Medicare (headed by former deputy minister Ken Fyke) devoted less than a page and a half to a direct discussion of wait list issues. While there is no specific recommendation in the Fyke Report of April 2001, aimed at wait list management, the report does call for continuing the province‟s participation in the WCWL and for further research into the nature and causes of inappropriate wait times. Of particular interest to the Commission was the question of measuring the impact of waiting on health outcomes.

[38] 02WLSK
[39] 04WLSK

The formal response to the Fyke Report on the part of the government came with the release of the Action Plan for Saskatchewan Health Care in December 2001. Like the Fyke report, the section on waiting lists in the Action Plan was heavily influenced by the work of the WCWL. The plan includes aspects of both resourcing and management issues:

> Our health plan includes providing more money to our major surgical centres and improving co-ordination of waiting lists. As well, we will ensure our doctors use a standard "measuring stick" to decide who needs surgery, and who needs it first. And finally, we will break down the air of mystery around the surgical system by providing people with clear information so they know where they stand on the list and how they can ensure the shortest possible wait.[40]

It was through this plan that the Saskatchewan Surgical Care Network first began to take shape. It was the intent of government to set up a network like the SSCN which not only tracks waiting times but also keeps track of the fluctuations of the lists.

One participant who worked in the civil service at the time offered that

> there was always the intent to have the ability to have one surgical waiting list that was computerized that you could actually have confidence in and that: one, it was accurate and two, that you could use to plan the demand for those services down the road because that was something that had to exist and still doesn‟t exist today and it's such a huge challenge and we're a very small province.[41]

Though being a small province, in terms of patients and doctors has created a more manageable level of data that needed to be integrated into a wait list management system;

[40] Action Plan for Saskatchewan Health Care. P. 42. [http://www.health.gov.sk.ca/hplan_health_care_plan.pdf]
[41] 01WLSK

advocated by the WCWL insofar as it involved the creation of the assessment and priorization tools, the need to bring surgeons on side around the province and the establishment of the information technology (IT) appropriate for a province-wide surgical registry.

The development and roll-out of the SSCN was given over to the Acute and Emergency Care branch of the Department of Health. As is noted below, the role of at least some of the officials within the branch was often cited as having been a key factor in the successful implementation of the SSCN. The notion that complex and multi-faceted policy solutions often require champions is reinforced in the report of The Taming of the Queue conference held in Quebec in 2004. The report notes that one of the common themes in the area of wait list management across jurisdictions is the role played by key champions within the medical community who have helped bring physicians on side even when it meant convincing them of the need to change their own behaviour. What was evident from the Saskatchewan interviews was that not only were there key champions for the SSCN in the medical community, but also within the civil service that kept the process moving forward despite the bumps in the road.

The assessment and priorization tools eventually adopted by the SSCN were based on those developed by the WCWL, but the government of Saskatchewan chose (for reasons that were never made clear) to not independently validate them. This caused some level of resistance within the physician community and their eventual acceptance by doctors was, it appears, the result of efforts made by those who had become the network"s key advocates within government and the medical community.[45]

Interjursidictional Learning

[45] 07WLSK.

While waiting list policy evolved as government learned from it's own research and experiences, it must also be noted that government learned from other jurisdictions. The most obvious example is the province‟s participation in the WCWL work in collaboration with other provinces, health authorities and stakeholder groups. As part of its own work the WCWL made a conscious decision to survey both the domestic and international scene for an understanding of the processes being developed beyond western Canada. Ontario‟s experience with the Cardiac Care Network was repeatedly cited as a key inspiration not only for the work of the WCWL but within the Saskatchewan Department of Health during the development of the SSCN. As

Internationally, Saskatchewan looked especially to the United Kingdom and New Zealand for help. In describing recent initiatives in New Zealand, Macdonald et al note: "New Zealand has adopted a direct management approach to the issue of waiting lists, through the development of priority criteria"[49] to be able to assess need for surgery, to ensure "consistency and transparency in the provision of surgical services," and to "provide a basis for describing the kinds of patient who will not receive surgery under various level of funding."[50] While priority tools have been implemented for various types of surgery in New Zealand, when compared to Ontario patients are waiting far longer in New Zealand for their surgeries.[51]

In the words of one interviewee these presentations from abroad were particularly instructive as the province began to move the SSCN from a concept to a specific set of initiatives: "…actually it was through those presentations that we learned about…how we were going to structure the SSCN priority tools."[52] The British system is based on a time variable and categorizes patients based on what is thought to be an appropriate amount of time before surgery. The New Zealand system is closer to what was adopted for the SSCN; the priority criteria tools that are based on need and the ability to benefit from treatment. The SSCN became a hybrid of these systems using priority criteria and then categorizing based on how long of a wait they should have.

Representatives from Britain‟s National Health Service provided more tangible support to the creation of the SSCN. In the process of developing an appropriate

[49] McDonald et al. p. 293.
[50] Ibid.
[51] Ibid.
[52] 03WLSK.

information technology infrastructure for the network Saskatchewan eventually

It is interesting to note that although some actors within the health system were less than enthusiastic about the SSCN, there was little in the way of organized opposition from stakeholders, especially physicians. One SMA staffer did not "recall the SMA having any meaningful input into the design of [the SSCN]."[56] This same participant noted that while many policies that came out of Saskatchewan Health are perceived to have an anti-physcian bias, the "SSCN is probably one that‟s kind of neutral."[57] It might also be instructive to note again that the traditional physician response to wait lists was to argue for more resources to increase capacity. But that strategy had clearly failed to produce lasting results under the WLFI and, without the proper management of wait lists, it was impossible to know where exactly to target those resources or even to insure that new dollars allocated to health districts were being spent on increasing surgical capacity. Despite the prospect that the SSCN would have some impact on how physicians and surgeons practiced medicine, the SMA remained officially neutral

implementation, officials within government noted that what they accomplished relied heavily on the support they received from those physician-champions. While the civil service may have been the spearhead to the program, some individual physicians were involved during the decision-making process.[59]

As with organizations like the SMA, the regional health authorities (themselves relatively new entities stemming from the post-Fyke report decision to move from 32 health districts to 12 regions) appear to have limited impact on the decision to move forward with the SSCN. One interviewee suggested that this might well have stemmed from the fact that the RHAs themselves had no particular solution to the problem themselves (either individually or through their lobbying and bargaining organization – the Saskatchewan Association of Health Organizations). In the final analysis, it was noted that the RHAs: "were involved in the SSCN, I mean they inputted into it. It‟s not like it came as a total surprise to me or others. But to suggest that we had an appropriate level of ownership over the problem, I think that was a problem…Up until today part of the…challenge in implementation has been that the Regional Health Authorities haven‟t taken enough ownership."[60] "The fear right from the get go is that we get this registration in place, set these targets, go with the public information and we‟re no further ahead because the Regional Health Authorities weren‟t in a better position to be able to manage the problem."[61]

If the role of physicians and regional health authorities was, at best limited, then other stakeholders appear to have had even less input into the process. A civil servant involved in the process told us that other groups were interested at the outset, but

[59] 12WLSK.
[60] 04WLSK.
[61] Ibid.

accomplished in a variety of ways. Individually doctors made the case to patients (and to the media) that the length of wait times and the length of wait lists were the product of too few surgeons, too few operating theatres and artificial limits on the number of specific surgeries that the system would accommodate. Collectively the profession lobbied the government that increasing resources to the system to „buy" more surgeries would reduce both the length of individual wait lists and the overall wait time spent on those lists by individuals.

At the same time, there were clearly different understandings of what the apparent shortage of resources meant. For some, the growth of wait lists and the lengthening of wait times were, in effect, a bulge created by earlier attempts to restrain health spending both on the part of the provincial government but also on the part of the federal government which had cut transfers to the provinces in the mid-1990s. Thus, the wait lists were evidence of a pent-up demand that had been artificially induced by outside forces and could be alleviated by short-term infusions of resources. For others, though, the lack of resources within the system was deemed more fundamental insofar as medical advances had increased the system"s ability to offer relief to a wider range of patients and thus necessitated a permanent increase in surgical capacity within the province.

However the shortage of resources was viewed, strategically the line of analysis was attractive to the government insofar as it provided a clear policy prescription that promised immediate and measurable results in a relatively short time period. And it could do so for a relatively low price both in terms of the amount of money involved but also in terms of disruption to the system. There was no „reform" involved in buying more surgeries or actively recruiting more surgeons both to the major centres of Regina and

Within the bureaucratic arm of the government there was a growing insistence that the government needed to pay more attention to the research evidence that suggested the problem was more complicated than had been previously articulated and that the solution – for want of a better word – required a more systematic approach. In short, individuals within Saskatchewan Health, armed with independent analysis by outside researchers, began to point to the idea that the „wait list problem" stemmed as much, if not more, from the way in which the system allowed lists to be managed by individual doctors, hospitals and health authorities rather than from a simple lack of resources.

Whereas the WLFI had been a relatively high profile response to the issue, the subsequent actions of the Saskatchewan government were decidedly less so. The decision to engage actively in the Western Canada Wait List Project indicates, it seems, an acceptance on the part of the political leadership of the arguments made both within and without the government over the need for better data and a more systematic approach to the analysis of the wait list/wait time issues – one that might yield more successful policy options. The government"s participation with the WCWL resulted from a coalition of independent researchers, key bureaucratic champions within the department and key institutional representatives of stakeholder organizations all making the same case to the government – there needed to be better research, better data and more fulsome reform of the way in which wait lists were managed.

communities in the province) on a case by case basis while pursuing a parallel course action couched in the langu

embraced by political actors and, arguably, by some bureaucratic actors – to increase resources within the surgical system had no lasting impact on wait lists and this may have presented the civil service with the opportunity to press for a different approach.

The dilemma, of course, is that the process of getting an initiative like the SSCN up and running requires a significant up-front investment of time, resources and expertise while providing only incremental improvements in the shorter term. The five goals of the SSCN noted at the outset are, in effect, cumulative in that each serves as a benchmark that needs to be hit to get to the next goal – first the data, then the registry, then the targets, etc. This is not the kind of health policy innovation that is immediately attractive to either governments under fire for a particular problem or to stakeholders that will be forced to adapt to a new way of doing things. But having made the investments in the processes developed by the WCWL and, absent any other alternative being seriously championed either inside or outside of government, the vacuum was filled by the advocates of the registry.

The development of the SSCN emerged, in its earliest form, as a conceptual solution in light of the failure of the WLFI. If global increases in resources were not having the desired effect then it could be assumed that resources needed to be targeted. But in the absence of reliable data on wait times and the length of lists the government could not target those resources. The most effective way to insure reliable data, the argument went, was to restructure the way in which wait lists were managed and that meant centralizing the lists into a single registry.

What drove this idea through the system into the eventual creation of the SSCN was the coalition of champions mentioned above. Key advocates of the „central registry"

were in positions of influence within the bureaucracy (and were instrumental in bringing political actors on side to the proposed approach and acted as mediators between the researchers and the government) as well as within the provider community (who were prepared to expend personal political capital to demonstrate that any perceived threat to physician independence was minimal). Political support for the incremental work of the

when the public realizes that it still a long way from that. Being hard-pressed for good news on the waitlist front the temptation for a government to promote the SSCN as *the* solution (rather than merely part of the solution) was understandable. But the SSCN has seemed to have some success in reducing wait times, though it still remains an issue for the public at large for whom the SSCN remains relatively unknown.