Wait List Management and Reform in Newfoundland and Labrador: What is the Prognosis?

Stephen Tomblin and Jeff Braun-Jackson

Memorial University of Newfoundland

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All jurisdictions in Canada are experiencing problems with waiting lists. Despite this, bringing about reforms has not been easily achieved across policy and political systems. Since the 1990's, there has been a growing sense of national political- policy crisis over waiting times and much pressure to focus attention on the problem, define it, and then come up with better solutions. This has been reflected in new commitments made in intergovernmental health accords, public pressure and media commentary about the need to rethink how health services are planned and delivered, as well as various examples of formal and informal experimentation in waiting list management across the country.

Despite informal collaborative efforts to deal with governance issues through intergovernmental Health Accords and the like, effecting change in a complex health care system organized on a provincial basis has proven most difficult. In the provinces of Alberta, Ontario, and Saskatchewan, waiting list reform has been an area that has received much more formal attention. On the other hand, other provinces (such as Newfoundland and Labrador) have not taken the same kind of formal political-policy steps to rethink and reform waiting lists. This provides us with an opportunity to further investigate why certain jurisdictions introduced political-policy reforms, while others did not.

One of the most salient issues in health care today is understanding the drivers and contextual factors that influence or cause policy reforms or lack thereof. We are interested in comparing and contrasting reform versus non-reform decisions across but also within provinces for different health care reform policies. For example, while this case-study deals with waiting list reform for Newfoundland and Labrador which was a "no-go" we will also examine the history of regionalization which was a "go" decision.

Informed by advice from all jurisdictions and key stakeholders and recent grey literature on health care reforms, our project describes the challenges of facilitating health care reforms in a complex federal system. In Canada, each jurisdiction remains responsible for developing and implementing reforms. Despite the influence of a national system that seeks to promote common shared objectives, share information, and work together in making sense of new challenges and circumstances, replacing each provincial society's governance system (which includes many public and private stake-holders) has proven to be easier said than done. As a result, there is much need to better understand the governance systems that have been built at the provincial level, the embedded mental maps, interests, and institutions that have been relied upon to define problems and form common perceptions of reality, and finally, to investigate the prospects for promoting a common pan-Canadian approach to reform, creating common systems of knowledge and restructuring health services.

Our approach is straightforward. We have produced a framework that allows us to consider the experiences of provinces in dealing with new problems and finding out more about how they dealt with them. For some, the approach involved reforming instruments and practices of governance. For others, there was less interest in searching for new ways of governance and introducing formal reforms. Our comparative approach to reform or lack thereof provides an opportunity to assess the relative importance of

institutional, interest, ideational, and external variables that influence reform outcomes. We seek to better understand different public policy processes and contexts in order to create new insights to better understand the key factors that shape and influence patterns of health governance and restructuring at the provincial level.

The following paper deals with the issue of formalized approaches to reforming the management of waiting lists and why Newfoundland and Labrador never went very far in adopting such reforms. The information comes from public documents and interviews carried out with decision-makers and other stake-holders.

The academic literature, and especially political science offers different perspectives on the reform or lack thereof of health policies and programs. How or whether issues or problems appear on the radar screen seems to be influenced by various factors, including the level of crisis, alternative ideas, institutions and interests, leadership, and resources available (or not) for creating new forms of knowledge, building new coalitions, and institutionalizing new partnerships, innovations and mental maps. As the literature tells us, common issues or problems do not always produce the same response everywhere. For example, modernization theorists forecast that federalism would become obsolete and centralization was the way of the future. They were wrong in the case of Canada. Canadian federalism has promoted diversity and this is reflected in the ongoing struggle to reform the health care system based on a common framework or model.

Patterns of policy framing and discourse in Newfoundland and Labrador have been influenced by lack of resources necessary for experimentation, and rural-urban divisions that have made it difficult to create common perceptions and shared agendas. Such a context has also complicated the task of building the kind of coalitions required or necessary to contest the legitimacy of the old regime. The power and autonomy of established interests that underpin health governance should not be underestimated nor should their ability to adjust and survive in a complex policy world.

Whether an alternative approach to reform (alternative policy frame) is successful or not depends very much on the policy ideas that define the new reality, the institutions that are relied upon to debate issues, the interests connected with these, communication opportunities, resources and political incentives to move in a new directions. There are different perspectives on the explanatory powers of ideas, institutions, and interests and we will rely upon these in our case-study to generate new critical insights on which factors need to be in place to facilitate health care reforms.

Contextual factors such as demographic shifts, urban-rural divisions, technological change, modernization and globalization all create common pressures for political institutional and policy change. Yet, despite the views of modernization, globalization and other universal thinkers, societies do not always respond the same way to common circumstances or changing realities. Rather, other theories suggest that whether policy-political changes occur or not will depend on the political actors and social forces that play a role in either promoting or constraining the impact of contextual factors and associated reform visions competing for power. Within a complex federal system with a

strong level of respect for diversity and multi-level governance, it is really not surprising that common problems and underlying contextual factors might create problems for universal, pan-Canadian solutions. In reality, such big changes have been difficult to manoeuvre through formal and informal provincial systems of power-sharing and networking that must be co-opted or replaced in any push for policy reform. We are interested in learning more through our case-studies about the challenges associated with quick policy responses, the pros and cons of a fragmented policy-political system, the arguments for incrementalism, and so on.

Newfoundland and Labrador did not join Canada until 1949. The province has a strong sense of identity, and has tended to be suspicious of attempts to define problems and impose solutions based on the universal experiences and visions created elsewhere. In 1949, Joey Smallwood embraced the idea of modernization and went out of his way to create a new regime. But such a top-down, leader-centred, universal approach created much suspicion, and made it difficult to develop the kind of common perceptions and shared agendas required to integrate different interests and values. In the 1970's, Newfoundland nationalism emerged and there has ever since been much suspicion about embracing outside visions that do not take into account local circumstances. Consequently, there has been much resistance to simply accepting outside perceptions and reform agendas.

Historically speaking, Newfoundland and Labrador has not always benefited from the frames, or mental maps that have been designed to help actors identify and define problems and construct solutions. Prior to Confederation, the practice of accepting competing visions and prescriptions never seemed to work in dealing with changing circumstances.

For example, the decision to build a railway, promote agriculture, and the like, have worked against new calls for universal solutions, and those seeking coalition support of new initiatives, new forms of management, data collection, and knowledge creation. Many of these experiments in the past failed to produce results and this, along with powerful embedded idealized myths about the place as a vibrant, self-reliant society, has worked against external calls for reform. Nor has there been the kind of resources available for contesting the power of these expectations, regimes and policies from within.

On the other hand, Newfoundland and Labrador has had a long history of informal innovation. It has a small population and this makes it easier to work informally in communicating information, creating shared frameworks, and producing mental maps. In the past, there was much reliance placed on the church, doctors, social movements, and other social forces in prescribing, and developing innovative initiatives required for addressing new challenges and changing circumstances.

For example, William Coaker and the Fisherman's Protective Union emerged in the early 20th century to protect fishers from merchants and to reform the fishery in a way that would produce more wealth and how it was distributed. This populist movement

established co-ops, challenged the power of the church and merchants, and offered a competing vision for the future. While the movement failed to achieve all of its objectives and become fully institutionalized, it did focus more attention on the need for reform, and there were subsequently, changes in the way problems were defined and addressed.

Toblin's recent work on Coasts Under Stress, argues that in the history of health restructuring in the province, internal and external factors (especially the nature of the political economy) shaped power-sharing, knowledge creation and competing models of health. Viewed in this way, the health care system in Newfoundland and Labrador has always been highly localized, decentralized, and highly diffused. Yet, these locally controlled, informal experiments featured much experimentation and innovation.

To be sure, there has been a long history of experiments with cottage hospitals, mid-wifery, and in the case of Sir Wilfred Grenfell, attempts at promoting interdisciplinary, community, population-based, eco-balanced approaches to health in the province. In fact, there is some evidence to suggest that the change to more universal, formal, bio-medical models wiped out local innovation and experimentation. Programs such as mid-wifery were knocked out by policy regulations. What is more, the increasing power of doctors and bio-medical forms of knowledge creation brought about fundamental changes in the public discourse. It also made it more difficult to contest structures of power and dominant visions. Despite all of this, Newfoundland and Labrador is a place that has relied on informal, local structures to define issues and problems and find solutions.

Understanding the Context

Newfoundland and Labrador does not have a formal system for wait list tracking and management. Instead, the provincial government has typically relied on informal networks of physicians and surgeons to manage patient flows. The province has also negotiated agreements with other jurisdictions so that patients can receive necessary medical treatments that can not be done locally. It is a rather decentralized, informal approach to organizing health care priority setting and delivery.

As indicated above, our purpose is to uncover the anatomy of a "no go" case with respect to wait list reform. We will first provide a detailed overview of wait list management and reform in Newfoundland and Labrador since the early 1990s. Next, we will provide answers to six key research questions to ascertain the state of reform in the province. Finally, two crucial conclusions can be drawn from the research on wait list management and reform in Newfoundland and Labrador: first, the issue has barely been visible on the government's radar screen and second, there is a dearth of resources available to properly manage and track patient demand for medical services in the province. Or, for that matter, to make it possible to contest the legitimacy and power of the old regime.

TABLE ONE: SELECTED ECONOMIC, SOCIAL, DEMOGRAPHIC AND HEALTH MEASURES FOR NEWFOUNDLAND AND LABRADOR[1]

Variable	Measure
Population	515,946 (April, 2005)
Gross Domestic Product	$19.563 billion (2004)
Per Capita Income	$24, 677 (2004)
Unemployment Rate (unadjusted)	12.5% (June, 2005)
Employment Rate	73.6% (2000)
Average Couple Family Income[2]	$56,500 (2001)
Unemployment Insurance Incidence[3]	36.2% (2001)
Economic Self-Reliance Ratio[4]	77.5% (2001)
Home Ownership	78% (2001)
Average Value of Dwellings	$76, 285 (2001)
Life Expectancy	77 years (2001)
Rate of Population Obesity[5]	39% (2001)
Rate of Smoking for Population 12 years+	25% (2001)
Self-Assessed Health Status[6]	79% (1995)
Population receiving Social Assistance	13.8% (2001)
High School Diploma or higher[7]	60.4% (2001)
University Degree (Age 25-54)	12.8% (2001)

Table One contains several measures with respect to Newfoundland and Labrador's demographic, economic, health and social position. Several of these measures are crucial with respect to the province's ability to initiate meaningful reform in terms of wait list management. First, the province's population has been declining over the last decade. In particular, the provincial population declined by seven percent between 1996 and 2001. Out-migration has been a feature of Newfoundland and Labrador for decades but the problem was exacerbated during the 1990s as a result of the cod moratorium in 1992 and the severe reductions in provincial spending in order to slay the deficit dragon. A majority of those leaving the province tend to be young, educated and women of child bearing years. Not only is the population declining, it is rapidly aging too. Newfoundland and Labrador's median age of its population is among the highest in the country.

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[1]. Sources: Newfoundland and Labrador Community Accounts; Newfoundland and Labrador Statistics Agency.

[2]. Measured as the total income of all the couple families divided by the number of such families. The measure excludes non-family persons and lone-parent families.

[3]. Measured as the number of people receiving Employment Insurance during the year divided by the number of people in the labour force. The labour force here is defined as the number of people in receipt of Employment Insurance or employment income within the year.

[4]. Defined as the ratio of market income from all sources to total personal income. The ratio of 77.5% means that of all income flowing into the province, 77.5 % came from market sources and 22.5% came from government transfers.

[5]. Based on the population 15 years and older with a BMI greater than 27.

[6]. Measures the personal assessment of one's health.

[7]. Population aged 20 years or older who have completed grade 12.

Second, while the province has begun to experience remarkable economic growth as a result of revenues flowing from off-shore oil developments and resource extraction (nickel at Voisey Bay in Labrador), the benefits are largely confined to the metropolitan St. John's area and the Avalon peninsula. Rural or "outport" Newfoundland has suffered a tremendous economic decline due to the loss of the in-shore fishery, cuts in federal unemployment insurance and out-migration coupled with a lack of educational opportunities. In rural areas, providing basic health services has always been challenging and the province is typically preoccupied with issues such as the retention and recruitment of physicians, the provision of primary care services, health human resource concerns and the location of hospitals and other medical facilities. In rural Newfoundland, health is a major economic engine. It matters economically, since the system is a large employer that pays good wages in areas where rates of unemployment and social assistance incidence are high. Having access to health services also matters for other industries hoping to recruit and maintain human resources.

Third, unlike other areas of health reform such as regionalization and alternate physician payment, wait list management, while acknowledged as a significant concern, has not seized the attention of decision-makers. Why is this the case? Several explanations have been offered including:

- No formal management structures and system of communication in place across the province;
- Not an explicit component of the province's Strategic Health Plan;
- Ad hoc management of lists by physicians;
- Interest in the issue by government is usually triggered by external factors such as federal government reports, other provincial initiatives and media reports charting the public's frustration;
- Wait list management is localized to the St. John's region, and
- Concerns about equipment, technology and health human resources have influenced the evolution of this issue in Newfoundland and Labrador.

In Newfoundland and Labrador, there has been little in the way of formal province-centred wait list reform. What typically transpires is an ad-hoc response on the part of government to any crisis where short-term solutions tend to be emphasized. For example, in 1997, the Minister of Health announced that due to long wait times for cardiac surgery, the provincial government had made arrangements with hospitals in Halifax and Saint John to perform these procedures on Newfoundland patients. The provincial government estimated that 50 people would be transported for the surgery. The Minister went on to announce that

"Government and the Health Care Corporation of St. John's are working to increase our capacity to perform cardiac surgery through dedicated ICU space and expanded operating facilities that will increase our ability to perform 12 procedures per week on a consistent

basis, up from approximately 10 per week, which is the current average".[8]

What exists in Newfoundland and Labrador is, in reality, not only a highly decentralized, diffused, territorial system of delivery, but in addition, separate silos or systems for managing and delivering cardiac, mental health, long-term care, and other programs. Each system relies upon its own mechanisms, cultures, and processes to define and solve problems. The locus of power and ability to pressure for change varies from system to system. In addition, in some of these systems, the stakeholders who act as agents for the state enjoy much autonomy and capacity. What complicates matters further is that the challenges and problems within any particular location or system of delivery, may not be identical. This makes it difficult to agree on common objectives, build support and promote new forms of integration and regulation across systems. Such a complex system of waiting list management creates a number of challenges for civic engagement or reformers who would like to see a more integrated and formal approach.

The only specific undertaking identified with respect to wait times for medical procedures in Newfoundland and Labrador is found in the Department of Health and Community Services paper *HealthScope: Reporting to Newfoundlanders and Labradorians on Comparable Health and Health System Indicators* (2002). This document is part of the effort of health ministries across Canada to select and report on a set of comparable health indicators. As such, it would be considered an external attempt to reach a broad consensus, change the discourse, and build support (not only across the country) but also across the silos which are relied upon to define and address various health challenges.

Despite such initiatives, contesting the power of ideas, interests and institutions (either formal or informal) within each embedded silo has proven very difficult. In a clear attempt to focus attention on this issue, the *HealthScope* document examines wait times for the following procedures: cardiac surgery; radiation therapy for breast cancer and prostate cancer and specialist physician visits (MRIs, CT Scans and angiographies). In an era of New Public Management and federal cutbacks, the purpose of the discussion was to focus public attention on policy effectiveness and raise questions not only about current circumstances, but what might need to be done to change the status quo. Such evidence was important not only in the provincial battle for public opinion support in the fight over federal cutbacks, but in addition, in separate contests over financing and calls for more regulation and integration across different wait list systems or silos in the province.

According to one decision-maker, when discussing the fight over unilateral federal cutbacks, "you know the fiscal pressures were always there: but once provincial governments were out rallying against the federal government for taking their money and saying that we now have less money for health care, the provincial governments, I suppose, are their own worst enemies in a way and we didn't mind having people complain about waits lists because it used to help us to go the feds and say we need more

[8] . Government of Newfoundland and Labrador, Department of Health, *News Release*, May 14, 1997.

money (Respondent 4). To this point, the effort to promote a new public discourse was designed to allow more discussion of current realities, develop common perceptions and innovate together. On the other hand, assembling a wide range of information on current realities did not by itself guarantee a new pattern of federal fiscal realities nor did it ensure that new linkages would be built across other internal silos. Indeed, some of this information was exploited to get more resources into each silo. In the end, this competition for more resources and autonomy did little for the goal of integration and challenging the status quo. Nor did it provide much incentive to develop common perceptions, objectives, or the kind of vision required for promoting new forms of integration and interaction among multiple stakeholders. These political and institutional factors did little in developing the new ways of organizing, communicating, and interacting. All of this worked against the change process.

More fundamentally, the public discussion generated much useful information for a continuing learning process that a wide range of actors could respond, adapt, and innovate. Whether the current regime survived or not depended on how it responded and dealt with changing realities and competing alternative visions. Put simply, it was a struggle between supporters of incremental changes versus reformers who preferred challenging the old sources of power and erecting a more integrated framework for health care planning.

As indicated by the report, with respect to cardiac surgery, in particular a coronary artery bypass grafting (CABG), the wait times in Newfoundland and Labrador are measured by tracking the number of days that have elapsed between a cardiac catheterization and CABG surgery in a given period (quarter). The wait period for this procedure could be used "to enhance the patients' understanding of their disease and to learn how to reduce their risks for future cardiac problems".[9] In 2000-2001, 600 patients waitlisted for CABG surgery in Newfoundland and Labrador actually received the procedure. The average number of surgeries performed monthly varied between 40 and 60. The estimated wait time for bypass surgery is four to five months. These figures do not include new patients being added (on average 15 per week) nor does it include those who received other cardiac procedures in combination with a CABG.

"In Newfoundland and Labrador, patients who require urgent and emergent CABG surgery have timely access to services. However, those on the elective wait list have significantly longer wait times. At present, approximately two-thirds of the elective patients awaiting cardiac surgery have been on the wait list longer than six months, more than one-half have been waiting longer than one year".[10]

With respect to radiation therapy for particular forms of cancer, waiting times are a function of such factors as rising rates of cancer among the population, increased referrals for radiation treatment, human resource management and funding.[11] The recommended

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[9] . Government of Newfoundland and Labrador, Department of Health and Community Services, *HealthScope*, 38.
[10] . Ibid, 40.
[11] . Ibid, 41.

waiting time for radiation therapy is a maximum of four weeks as described by the Canadian Association of Radiation Oncologists. The average wait time across Canada is 8.9 weeks. In Newfoundland and Labrador, the average wait time for radiation therapy for breast cancer in 2001 was six to eight weeks and for prostate cancer eight to ten weeks.

For specialized physician services such as MRIs, CT Scans and angiographies, the median wait time for non-emergency surgery was 4.3 weeks in Newfoundland and Labrador in 2001 (the same figure as Canada).

The Williams administration published a second *HealthScope* report in November, 2004. Unlike the earlier report, this focused mainly on primary care and much less on wait times for specialist physicians, diagnostic procedures and surgery. Briefly, the report noted that residents of the province reported a median wait time of 4.3 weeks for non-emergency surgery (hip and knee replacements and cataract surgery); 46% of provincial residents waited less than one month for their non-emergency surgery and 44.1% waited between one and three months, and 9.9% of residents waited longer than three months.[12]

The average wait time to see a specialist physician in the province was 4.3 weeks with 43% of residents reporting that they had visited a specialist within one month of waiting. Nearly 38% of residents reported waiting between one and three months to visit a specialist.[13] Wait times for diagnostic services such as non-emergency MRIs, CT scans and angiographies was two weeks for residents of the province. A majority of residents, 59.6%, received their diagnostic tests within one month; 24.2% received their procedures between one and three months and 16.3% waited longer than three months.[14] Excluding paediatric diagnostic procedures, significant improvements have been achieved in the province's wait times due to increased spending on equipment and the addition of a second magnetic resonance imager in Corner Brook in February, 2005. The new imager has lightened the wait times for MRIs as residents in central and western Newfoundland as well as Labrador no longer need to travel to St. John's. The current health minister notes that the new MRI allows physicians to better monitor their patients and makes it less onerous for the integrated regional health authorities with respect to recruitment and retention of general and specialist physicians.[15]

Viewed together, this information does not create the impression that the current system was in a state of crisis or that fundamental changes were required. Rather, it would appear that while there were challenges associated with ensuring timely access to services, there was little political incentive to create an entirely new system or model of ideas, interests, and institutions. Besides, regionalization offered a new approach and a way for dealing with diverse problems in particular locations. Aside from the conflicts

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[12] . Government of Newfoundland and Labrador, Department of Health and Community Services. *HealthScope 2004: Reporting to Newfoundlanders and Labradorians on Comparable Health Indicators*. St. John's, NL: The Queen's Printer, November, 2004, pages 19-22.

[13] . Ibid, 22-23.

[14] . Ibid, 24-25.

[15] . Government of Newfoundland and Labrador, Executive Council. *Premier Williams Officially Opens MRI Suite*. February 17, 2005. Accessed at www.releases.gov.nl.ca/releases/2005/exec/0217n04.htm.

with Ottawa over federal transfers, there was little evidence of political protest and political challenge, at least in a way that was coordinated and based on an alternative vision. It is also important to take into account that the province was involved with various policy experiments[16], and as a result, there may not have been much interest in introducing other reforms.

There is evidence that there were efforts to ensure new challenges and realities were constantly assessed, explained, and not ignored. For example, recent work on wait lists has been undertaken by the Newfoundland and Labrador Centre for Health Information (NLCHI). In 2002, the Performance Indicators Reporting Committee (PIRC) for Newfoundland and Labrador examined wait list indicators for radiology, home support and hip and knee replacements. As well, the NLCHI developed a list of subjective wait list indicators derived from the Canadian Community Health Survey (CCHS). The Centre has been asked by the Department of Health and Community Services to examine whether Newfoundland and Labrador should adopt an Alberta style wait list registry (Respondent 7). In a small province like Newfoundland and Labrador, knowledge and scenario construction depends very much on a small number of research institutes that have close links with government. Other groups do not have the same resources to construct alternative explanations and scenarios. Besides, there does appear to be much interest in constantly assessing what others are doing and considering alternative strategies, but only if it makes sense for the province.

A second initiative established by the province is a pilot project for wait list management at the former Health Care Corporation of St. John's.[17] The main reason for the creation of this pilot project was the lack of vision of how wait lists for various medical procedures should be managed.

One of our respondents stated that "we had 50 different groups having wait lists and they were all managing them in a different way and so we [Health Care Corporation of St. John's] decided that we would establish a wait list management group" (Respondent 1). In 2003, the Health Care Corporation submitted a proposal to the province to hire a physician and upgrade computer software in order to create a manageable wait list system. The province agreed to the Corporation's request and funding was provided for a three year pilot project. The goal of the project is to eventually establish a permanent wait list management system à la the Western Canada Wait List Project.

Another respondent supported this noting that "we're now under pressure where we are having to look at more formal means in managing this formal process" (Respondent 2). The pilot project was justified because the health system lacked sufficient resources to

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[16] . These experiments included the elimination of denominational control over the elementary and secondary school systems; the Strategic Social Plan; the establishment of regional economic development zones and boards to oversee development, and the creation of a community accounts data bank to measure change or the lack of change.

[17] . This entity was abolished in April, 2005 and is now a part of the Eastern Regional Integrated Health Authority. The previous institutional and community services boards have been abolished as a result of the Conservative government's attempt to streamline health services through the creation of four integrated health authorities.

adequately track and manage patient flows for various medical and diagnostic procedures. The dearth of resources became salient insofar as policy makers were concerned around 2001 when individual patients and some physicians began to publicly complain about long wait times for procedures such as cardiac surgery. As well, a critical mass of young, new and innovative physicians have recently graduated from the Memorial University School of Medicine or have returned to the province from elsewhere to practice. These physicians have demanded that changes to wait list management occur (Respondent 1). The pilot project was created to address these concerns. The project started earlier this year and there is not sufficient evidence at this point in time to determine whether or not wait times are being reduced. George Tilley, the former CEO of the HCCSJ stated that:

"We have some very crude data that would tell us that we can do better in terms of access for cardiac surgery, for urology surgery and access to our MRI [machines]. If there was additional [funding] available, targeted funding for that purpose, instead of into the general system at large, then I really think it has the potential of benefiting us."[18]

Until the pilot project is fully implemented, here is how the current wait list system works. First, physicians complete a request for an operating room (a surgical booking) and send it to the department responsible for patient flow. Second, five surgical booking clerks are employed by the department. They are responsible for entering patients' names into the computer system under the medical procedure that is being requested. Third, of the 60 plus physicians who perform surgical procedures, ten allow the department to manage their wait lists each week unless an individual doctor presents her own list of patients that she would like to operate on first. The department can then decide how the physician's other patients will be ranked in terms of surgery. The majority of physicians in St. John's are responsible for compiling their own wait lists for their patients. Fourth, five days prior to a patient's date of surgery, the physician provides her list of patients to be operated on for the specific date to the department. The department does not determine which patient will go first or second. The management system is "totally driven by physician preference versus consumer need" (Respondent 1). There is no provincial standard for wait list management.

The issue of wait lists is primarily concentrated in the capital region as all tertiary medical services in the province are carried out by the former Health Care Corporation of St. John's. Rural RHAs are not generally concerned about the issue. The four main areas where wait list management is most significant are home care, hip and knee replacements, cardiac and radiology/cancer. For hip and knee replacements, there are 17 orthopaedic surgeons in the province who perform surgeries for patients.

Newfoundland and Labrador has a health care delivery system that features much diversity. Such diversity exists across, as we have seen, the urban-rural divide. To complicate matters, each of the separate functional silos that operate within the system face dissimilar circumstances and have responded by adopting their own unique

[18] . CBC News Indepth: Health Care, September 10, 2004. Accessed at www.cbc.ca/news/background/healthcare/waiting.html

governance practices. Unless or until there is sufficient pressure or sense of urgency that one model should be imposed upon all communities and services within the province, it is unlikely more fundamental change will occur. In the end, whether change occurs or not will likely depend not only on the capacity and autonomy of each community and silo, but also the drivers and constraints for contesting and institutionalizing alternative visions for health delivery.

Each silo has its own traditions. One of our participants (Respondent 7) stated that for hip and knee replacements, the process is not at all scientific and standardized. There is no coordination among surgeons and no voice moving the management process forward. Cardiac wait listing is very high profile and is generally well managed since these procedures are only performed in St. John's. For cardiac surgeries, the team of surgeons meets on a weekly basis and ranks their patients on the basis of greatest need. These individuals are then operated on first while less severe cases follow. The system used by cardiac surgeons is efficient and operates completely outside the parameters of government. Wait lists for home support are notoriously difficult to track because each of the integrated health authorities is responsible for maintaining its own system. As one of our respondents noted, "we have no idea what the wait list is for home support in our province and there's probably a lot of reasons for that - one of them being there's also 14 health boards [2004] and each board has their own way of measuring that" (Respondent 7). Tracking wait times for cancer and radiological diagnostic procedures is similarly difficult because each physician operates independently of each other and negotiates with hospital departments to book surgeries for their patients regardless of the degree of need. As well, wait times for such diagnostic procedures have been exacerbated in the past by a lack of equipment and too few technicians to monitor the procedures (Respondent 11).

The initiative to reduce wait times has been health board driven and internal through the former Health Care Corporation of St. John's (HCCSJ). Because of external pressure in the form of public opinion, the former HCCSJ has examined the feasibility of establishing a public wait list for all procedures so that patients will have a good idea of how long they may wait for a specific medical service. The key driver for wait list reform is the national health agenda, not the provincial government. The partnership to improve wait times between the province and the public is in its infancy and for the government, the critical variable is outcomes. Government is more interested in making change to save money (emphasis on business cases) and requires evidence to see what works.

What are the roles played by the health boards with respect to wait list management? What are the different ways that problems have been defined in the debate over waiting list reform and who has been involved in such construction? Respondent 7 stated that only in St. John's has the board played a major role due to the fact that all tertiary services are performed only in this region. As well, Eastern Regional Integrated Health Authority (ERIHA) has more resources which means it is better able to develop innovation for managing wait times than are the smaller health boards. For hip and knee replacements, orthopaedic surgeons are driven by costs and financial incentives to perform procedures since they are given only one day per week in the operating room.

This means that surgeons will perform as many surgeries as possible to maximize their salaries rather than spreading patient scheduling over a longer period of time. With respect to home support and care, our participants noted there is some anecdotal evidence to link wait lists with availability of acute care beds. Many acute care beds are occupied in St. John's by patients from other parts of the province because the patients' own health boards lack the capacity to allow them to recover. Part of the problem rests with the lack of co-ordination among health board CEOs and board autonomy with respect to resource allocations. Another problem is the use of silo budgeting for health reforms in the province. We will return to these issues below.

Most recently, the Williams administration announced new spending to reduce patient wait times in a number of medical and diagnostic procedures. The 2005-06 provincial budget allocated a total of $23.2 million ($14.2 million one-time and $9 million on-going funding) to "improve access to key services by purchasing new medical equipment, modernizing diagnostic and medical equipment and expanding select services in all of the province's major health centres."[19] Funding was allocated for equipment including:

- A second MRI for St. John's to deliver 2500 new exams a year and reducing wait times by four months;
- New funds to replace two existing CT scanners with new multi-slice CT scanners at the Health Sciences Centre and St. Clare's Hospital (St. John's), delivering 4000 more exams per year and reducing wait times to two weeks;
- Funding for new ultrasound equipment for hospitals in Carbonear, Labrador City, Corner Brook and St. John's;
- New money to purchase four nuclear medicine gamma cameras for bone and thyroid scans and specific cardiac procedures delivering 2900 new exams per year;
- Four new mammography units in St. John's, Corner Brook and Grand Falls-Windsor delivering 10,700 more exams per year;
- A new endoscopy unit in Corner Brook and funding to improve the endoscopy unit in Gander with a reduction in wait times of 40 percent and delivering 3400 new exams per year, and
- Funding for new laparoscopic equipment in Corner Brook reducing wait times by 30 percent and delivering 350 new procedures per year.[20]

Funding was allocated for the following medical services:

- To increase cardiac surgeries by 184 cases annually and to improve access to echocardiograms (an additional 900 exams annually);
- The introduction of Visudyne, a new photo dynamic therapy used to treat macular degeneration for 200 patients annually;

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[19] . Government of Newfoundland and Labrador, Department of Health and Community Services. *Government Acts to Reduce Patient Wait Times; $23.2 million Investment Delivers 43,344 More Procedures Across Province*. March 21, 2005. Accessed at www.releases.gov.nl.ca/releases/2005/health/0321n10.htm.

[20] . Ibid.

- An increase in surgical capacity for joint replacement at St. John's hospitals resulting in an additional 340 operations annually;
- Additional supports for dialysis services in Carbonear and Gander allowing 30 patients to access care closer to their homes;
- Extending the hours of operation of the Newfoundland Cancer Treatment and Research Foundation centre in St. John's to allow cancer patients better access to chemotherapy and radiation;
- An increase in surgical capacity for cancer patients with a reduction in wait times of 30 percent and an additional 740 operations annually.[21]

The bulk of the funding announced by government came from the 2004 Health Accord signed by Prime Minister Paul Martin and the other First Ministers. As indicated above, approximately two-thirds of the funds announced are one-time only. Government has not formally committed to the establishment of permanent funding for either a wait list management system or for health human resources to be deployed to develop a mechanism for reform.

Six Research Questions

In this section of the paper, we attempt to address six key analytical questions to determine why the government of Newfoundland and Labrador has not adopted a formal system of wait time management for medical and diagnostic procedures, when other provinces have.[22] This document is informed by a research framework that is designed to help us better understand the factors that shape health care restructuring and reforms. The specific research questions to be addressed are as follows:

1. How much reform has occurred in wait list management and reform in Newfoundland and Labrador over the last decade?

2. Under what conditions has wait list management and reform occurred over the last decade?

3. Under what conditions has wait list management and reform not occurred despite widespread calls for it?

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[21] . Ibid.

[22] . Data employed to answer these questions have been generated from in-person interviews conducted by Stephen Tomblin. A total of ten individuals were interviewed. These persons have been or are currently employed in government, in the health system or in advocacy groups. The interviews were recorded on cassette tape with the consent of each participant. An individual was hired to transcribe each interview. Jeff Braun-Jackson then edited each transcript to check for accuracy. All data were coded using the qualitative software package N6. The coding scheme and tables are included in Appendices 1 and 2.

4. Is there a feedback loop between wait list management and reform and the conditions that have contributed to it thus making "second round" changes in the domain easier to achieve?

5. Do current conditions make wait list management and reform more probable than other types of change?

6. What can be done to create the conditions that make wait list management and reform more probable? What can be done to change the conditions that hinder wait list management and reform in the province?

Question 1

As indicated above, no formal, integrated province-centred mechanisms or institutions have been established to reform and manage wait lists in Newfoundland and Labrador. However, there have been some informal and reactive measures adopted by various governments over the past decade including sending patients outside the province to receive cardiac surgery (1997), funding allocations to reduce wait times for cardiac surgery and cardiac catheterizations (2001), and new funding to reduce wait times in the 2005 provincial budget. All of this experimentation has likely worked in support of incremental change and against more fundamental "big bang" approaches to restructuring. This is not to say that changes have not occurred. For example, over the past decade, we know that cardiac surgeons, as a group, have collectively pooled their resources to manage the provincial wait list for procedures and by most accounts this has been successful in addressing new challenges. The wait list management pilot project is now underway in St. John's to establish a permanent wait list. Whether these experiments will affect other silos will depend on the extent that there are common problems, shared objectives, a shared understand of what needs to be done, who needs to do it, and so on. It will also depend on creating a shared framework that is well resourced and able to facilitate the bringing together of multiple stakeholders in a common governance process that promotes coordination, policy learning, and evaluation.

It appears from our research that the government is required to act on wait list management and reform only when prompted by changes in public opinion or by media reports highlighting the plight of a particular patient. Two examples illustrate this reactive approach quite nicely. The first concerns three and one-half year old Mitchell Bishop of Paradise. Mitchell has been diagnosed with a mild case of cerebral palsy and also has a club foot that has not responded well to treatment. Mitchell's mother, Cindy Bishop, was told by administrators at the Janeway Children's Hospital that her son's wait could be anywhere between 18 and 24 months.[23] While urgent and emergent cases of children requiring an MRI are dealt with immediately, those that are not are forced to wait. As well, the MRI machine in St. John's is used only one or two days per month for children because sedation is generally involved in the treatment. This adds to the wait

[23] . Deanna Stokes Sullivan, "Two-Year Wait: Children's Hospital Can't Keep Up With MRI Demands," Telegram, October, 23, 2004, A1, A4.

time as well. Mitchell's mother is concerned that if his club foot is not treated in a timely fashion, it may affect his ability to walk and to be physically active.

A more horrifying story is that of Ryan Oldford of St. Phillips. Ryan is four years old and has already lost a kidney as a result of a Wilms' tumour (a form of kidney cancer). After his kidney was removed through surgery, Ryan's doctors referred him to a geneticist to determine if Ryan's remaining kidney was healthy. A Wilms' tumour begins with small, pre-cancerous cells that can only be detected through an MRI. The geneticist recommended an MRI for Ryan. However, when Brenda Oldford (Ryan's mother) contacted the radiology department at the Janeway, she was told there would be a two and one-half year wait for the procedure. Ryan had already waited nearly 18 months for an MRI. As Brenda Oldford remarked,

"I don't mind waiting if his kidney is healthy when he's six years old- I'll be a happy lady. But I've got to think about that for the next 2 ½ years, wondering if he'll be seven. If something is wrong, how mad would I be, when you've waited so long and all of a sudden you realize something was wrong and two years ago we could have done something about it?"[24]

The situation of Ryan Oldford is similar to that of Mitchell Bishop. Both children were suffering debilitating medical conditions that were not considered urgent or emergent by administrators. In the case of Mitchell Bishop, going public seems to have helped. Mitchell received an MRI scan on January 4th, 2005 approximately three months after his story appeared in the media.

Ryan Oldford's story, unlike Mitchell Bishop's, received national media attention. Stories appeared in both The Globe and Mail and The National Post pointing to a "crisis" in wait times for diagnostic procedures across Canada. Stories such as Ryan's have fuelled demands for more MRI machines and the creation of private, for profit medical clinics that offer such procedures more quickly than public hospitals. However, provinces that sanction private, for profit clinics may be in violation of the Canada Health Act and this is a significant concern for the federal government.[25] As a result of such publicity, the Oldfords were inundated with offers from individuals and hospitals across the country to offer a spot for Ryan to have his MRI scan done. While Brenda Oldford said she was overwhelmed by the generosity of so many, "[i]t's one thing to say not, I won't do it, I'll put my faith in the system. But then, in two years, if something [cancer] is there, I'll kick myself in the butt over it."[26] The Oldfords were on the verge of flying to Timmins, Ontario to receive an MRI scan when a clerk from the Janeway phoned Mrs. Oldford late in the afternoon on January 31, 2005 to tell her that a patient had not shown for a scan and that Ryan could be scheduled for the opening. Ryan received his MRI the following morning. As Brenda Oldford remarked,

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[24] . Deanna Stokes Sullivan, "MRI Wait-List Worries Mom," Telegram, January 6, 2005, A2.
[25] . Lisa Priest, "A Boy's Plight, a Nation's Problem," Globe and Mail, January 13, 2005, A1, A6.
[26] Lisa Priest, "Newfoundland Boy's Case Highlights Shortage of MRIs," Globe and Mail, January 14, 2005, A7.

"As a mother, I can make no apologies for wanting and demanding the best for my child. As a nurse and a Canadian, I wish this entire system worked this way for everybody. Ryan's segment is closed but this problem is a lot bigger than Ryan."[27]

These stories and countless undocumented others accurately reflect the provincial government's approach to wait list management and reform. As one of our respondents suggested, "wait list management is a very narrow policy issue. Even though it's getting a lot of attention, if you put it on your top 100 list, it would probably be around number 70 because of a general satisfaction with how it's being handled" (Respondent 5). Despite occasional news stories, waiting list reform has not been the kind of critical political issue that has been the basis of well organized political protest and policy challenge. Nor has it been easy in such a complex, competitive setting, creating the conditions required to mobilize a reform movement to contest for power.

A big challenge facing reformers is working across various systems that operate in silos. Another is connected with the problems of working through a major historical, urban-rural divide. The health policy community in Newfoundland and Labrador is not a monolithic entity, and as a result, it has been difficult building a strong coalition, network, or power-sharing system capable of contesting power, and constructing and reconstructing definitions, objectives, and strategies. In additions, it has also been difficult building the kind of capacity required to contest for power, provide alternative definitions/solutions, mobilize interests, and finally erect new institutions in support of a new regime.

Question 2

Most Newfoundlanders and Labradorians do not understand the issue and generally do not express negative feelings about waiting times unless their health is adversely affected. Our participants noted that the government is aware and takes seriously the consequences of poorly managed wait lists for medical and diagnostic procedures but lacks both the fiscal and health human resources to adopt strategic approaches to deal with the problem. When situations such as Mitchell Bishop and Ryan Oldford become public, government will attempt to act. However, such actions are regarded as myopic by members of the various medical constituencies across the province: "I think government would like to have good waiting times for the public. Whether they're seized with the subject, in my opinion, is another issue and I don't think they are because, again, I think there's such a strong preoccupation with getting through the pressures that, you know, looking at sort of ideal waiting times and so on is something that I don't they're particularly seized with" (Respondent 9).

Another set of conditions that has prompted some interest in wait list management and reform focuses on the costs of the health system. This is felt most strongly at the health board level, especially in St. John's where hospitals have sole responsibility for tertiary medical care. One of the underlying reasons for the establishment of the wait list management pilot project was to create a system that would better deploy scarce

[27] . Lisa Priest, "After 2 ½ years, Newfoundland boy gets MRI," Globe and Mail, February 2, 2005, A7.

resources in an efficient manner: "We have felt enormous cost pressures in the last two years in order to continue to do stuff; and part of our approach to try to respond to these cost pressures is to try to understand the right level of service to be provided and to understand the right level of service, you have to be able to understand the demand and to understand the demand, you have to know what the queue of services is that you're meant to serve" (Respondent 2).

The context underlying wait list management and reform and other health reforms in Newfoundland and Labrador in the past decade was harsh. The provincial economy took a major hit with the closing of the northern cod fishery in 1992, resulting in the loss of 35,000 jobs and severe dislocation for hundreds of rural communities; the national recession of the early 1990s acted as a drag on any potential job recovery; the introduction of the federal Canada Health and Social Transfer (CHST) in 1995 meant fewer funds for health care and forced the province to pay for a larger share, and the Wells administration enacted a policy of economic austerity by reducing the provincial civil service, freezing wages for public sector workers and capping expenses for hospitals. This context made health reform difficult (the exception is regionalization of health and medical services) in Newfoundland and Labrador. It is not surprising that wait list management and reform ranked low on the priority list for government given the overwhelming emphasis by decision-makers to keep the basic health system sustainable: "So waiting lists therefore... the lack of enough resources is partially because we have to scatter them so far; and then when you look at the tertiary care, then it's in a few areas. So it's a phenomenon of a large geographic area with a very small population" (Respondent 3).

Question 3

What are the factors that cause wait list reform to appear on the health radar screen? In Newfoundland and Labrador, internal factors most responsible include changes in public opinion as a result of media reporting and physicians' demands for better list management. External factors include national or pan-provincial reports on wait lists, reports from think tanks (for example the Fraser Institute) and meetings of federal, provincial and territorial health ministers. However, it is difficult to determine exactly when the provincial government became interested in the issue. Reform of wait list management systems has not occurred in Newfoundland and Labrador despite opposition calls for change and the ebb and flow of public opinion. As one respondent noted, "What I seem to recall more than anything is that individual cases would seize the attention of media and then the media and the Opposition would draw out the issue, but I don't think it was an interest group activity" (Respondent 5). Another respondent (11) stated that "I can remember the present Minister of Finance [Loyola Sullivan] always bringing this [wait list management] forward in the House about the wait list for cardiac surgery; and in fact, even spelling out the number of cases done per week and calling on the government 12 to 20 or whatever it was and now we're at 16 and now we're down here".

Another facet of the governmental agenda that respondents mentioned had to do with examples of reform from other jurisdictions, notably Alberta and Ontario. To what

extent, if any, did reform in other provinces contribute to or affect the government to act upon the issue of wait list reform? The short answer: not much influence. The key reasons why this is the case include the province's poor fiscal capacity and the lack of attention by government to the issue. Yet, given the challenges associated with fragmentation within the health care system and the fact it was more of an urban than rural issue, it was difficult developing a popular vision that could be relied upon to effect change. Predictably, the opposition had an incentive to raise the issue sporadically, but there were few opportunities or incentives to come with better alternative solutions. Rather, the tendency has been to push for more resources, sustain the current system and adopt a pragmatic, incremental approach. The fact that the province has a group of doctors that know one other may have worked against more ambitious reforms. A number of those interviewed kept referring to the fact that the context is different in Newfoundland and Labrador. There is not a large number of doctors and patients that require complex management tools to make sense of circumstances and ensure planners have access to the most innovative inventories and rational models. Rather, according to some of those interviewed, the informal systems that have emerged work just as well as more formal systems developed in other jurisdictions (Respondent 11).

The variance in which reform appears on the radar screen in Newfoundland and Labrador is determined, in part, by the individuals and groups who champion shorter wait times and increased access to medical and diagnostic procedures. Some groups that are highly visible and well funded (e.g., the Cancer Society, Heart and Stroke Foundation) can command the attention of both decision-makers and the mass media to bring the issue to the forefront. However, as some of our respondents noted, the media tend to pay attention only if the stories can prompt shock and outrage among the general public (see above with reference to Mitchell Bishop and Ryan Oldford).

Politically speaking, the issue of waiting lists has appeared sporadically and not all areas have received the same attention. According to one interviewee, "if you look at the area in the province where we have probably the best and only very good waiting lists the waiting trend is for cardiac, and cardiac surgery has been a highly political area … a hotspot for all governments for a long time" (Respondent 2). It was suggested that government was constantly paying attention to waiting times for cardiac care because it mattered politically. Yet, it was also suggested that "I don't think we've been challenged on the whole, total range of waiting lists: but given the movement toward guaranteed access to service in some of the political platforms that are coming out now, I wouldn't be the least bit surprised if that doesn't move in that direction." (Respondent 1) According to respondent 7, "Cardiac … our cardiac program has an excellent wait list system and it's reviewed by the team and given, the priority and given a spot and , you don't move up unless somebody who is not in more dire needs comes ahead of you so … and that is a really well supported, well utilized, well developed system. (Respondent 7) Other areas like mental health have more problems, but most complaints and political pressure tends to come from areas like cardiac care.

Another respondent indicated that while national reports (Romanow Commission) and First Minister Accords (2000 and 2001) focussed attention on the need to measure

parallel performance indicators, "it is really not on anyone's agenda in my opinion." In fact, "That was the first time we started looking at wait lists in detail and any concentrated manner" (Respondent 7).

An issue that kept getting repeated was the problem of working around the urban-rural divide. Since most specialized services are located in St. John's, there are problems associated with spending money there. As suggested by one interviewee, "I know there's competition here there is a stress, a tension between the amount of money that goes into St. John's and the amount that goes elsewhere" (Respondent3). Such is life in Newfoundland.

Based on our interviews, we can conclude that wait list management and reform was an issue that did not directly seize the government's attention in any sustained manner. Governments since the 1980s have tended to embrace the issue only when confronted with damning evidence from the legislative opposition, the mass media, federal forums and health groups. Much of the management of wait lists for specific medical procedures is done informally by physicians and surgeons rather than through a formal system established by government or the RHAs. In Newfoundland and Labrador, wait times are an important issue and patients are aware of delays in accessing procedures. The current wait list management pilot project underway is a step toward a formalized wait list system. Until the research is complete, Newfoundland's doctors, health professionals, decision-makers and politicians and patients seem content with the informal networks that have evolved.

There appears to be much support for incremental changes rather than radical changes in the province. For example, according to one interviewee, "I think it's just a reflection of the general hierarchical guard with which positions have been held in the authority structure in our health system in the past, and maybe that's because it's dynamic as you play it out. Maybe it's because of where we are and who we are. But physicians do hold a lot of power in this model: and, for the most part, they're very responsible and they do provide information that is reasonable and accurate. So it has worked in some sense – that people have been able to be priorized and in the sense they know themselves when they are clinically responsible for patients they would logically want to treat people who are in more urgent need of services more quickly. It's better for them in a whole host of ways – better treatment. So this has kind of worked" (Respondent 2).

Question 4

Is there a feedback loop between various health reforms in Newfoundland and Labrador that may make wait list management reform more likely? Unfortunately, health reforms in the province occur independently of each other. In other words, wait list reform is not necessarily connected to regionalization or needs-based budgeting models. Different sets of decision-makers may be involved with formulating and implementing reform. One of the persistent problems in health reform has been the lack of cooperation and

collaboration among different policy communities as to what reform should be like and how it should proceed. The initiatives (if we can call them that) that have occurred with respect to wait list management over the last decade have been spearheaded by physicians, hospital administrators and the former Health Care Corporation of St. John's. Since the First Ministers' Health Accord in 2004, limited funds have been distributed to the provinces for initiatives. As noted above, the current government has distributed these monies to purchase and upgrade equipment and to schedule more exams and procedures in order to reduce wait times. However, there does not appear to be any effort to link this approach to a population health model where prevention programs might be expanded to make people healthier thus ultimately reducing the need for certain medical procedures. The fact is that the provincial government is moved to act with respect to wait list management when it is confronted with stories that generate public outrage and embarrassment or when physicians demand that equipment and health human resources be deployed to improve patients' medical status. As one respondent laconically noted, "Well, I guess the consequences are that people have to wait longer. There's no management of long wait lists. You have to decide if you can manage it, first of all. I mean, right now, the management isn't there. It's just crisis intervention, right from problem to problem" (Respondent 10).

Question 5

Here we will attempt to speculate on whether current conditions in the province make wait list management and reform more probable than other kinds of change. The most significant change for Newfoundland and Labrador is the recently announced Atlantic Accord that will given the province some two billion dollars in offshore oil revenues. Much discussion has occurred among various constituencies as to how the money should be allocated. Premier Williams has indicated that he wants to take some time to contemplate how the funds might be distributed. However, given the current administration's emphasis on deficit reduction, we argue that a significant portion of the offshore revenues will be targeted in this sector. Health care is the single most important issue for citizens and this sector will certainly command additional funding. The Premier has recently announced funding to upgrade the cancer clinic in Grand Falls-Windsor but only did so after being embarrassed by the former Premier (Roger Grimes) as to how patients were being treated.[28]

Another factor concerns the recent changes to the province's health boards. As of April 1, 2005, the previous fourteen institutional, health and community services and integrated boards were abolished and replaced with four new integrated authorities: Eastern, Central, Western and Labrador-Grenfell. Government's rationale was to achieve cost savings by eliminating inefficiencies and top heavy management structures. It is far too early to tell whether the restructuring that has occurred will result in an additional push for a permanent wait list management system in the province.

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[28] . Sue Hickey and Wendy Houlihan, "Push Made for New Clinic," Telegram, Wednesday, March 30, 2005, p. A4.

In sum, the current climate is not any better or worse than conditions in the past for promoting wait list management and reform. We argue that reform will occur only if the federal government provides funding or the province can create a program that will not act as a drain on the treasury. But in addition, fundamental reform would require working across regions and silos. Funding by itself will not necessarily reinforce a common perception of the problem, its nature, and how it should be resolved. Conditions within each silo and region are very different, and unless or until ways can be found for promoting integration across systems and reinforcing common perceptions and agendas, it will be difficult to reorganize institutions, interests, and ideas in a new common direction.

Question 6

What, if anything, can be done to create favourable conditions conducive to the implementation of wait list management and reform? First, additional funding, preferably from Ottawa, would be a start. Second, the province must engage in broad consultation with physicians and physician groups, nurses, allied health professional and managers employed by the integrated health boards to devise a transparent and cost effective management and tracking system. The silo approach to health reform must be dismantled for any reform to be meaningful.

To understand the divisions created by this issue, we need to also be sure and not underestimate the competitive and decentralized nature of health governance in Newfoundland and Labrador and the different forces that shape the politics and sources of power around it. Nor should we underestimate how difficult it has been to obtain unanimous support for the project from key stakeholders whose power and autonomy should never be underestimated. The discourse over integrating planning processes and reinforcing common structures and systems of data collection and analysis is not new to the province. It was very popular during the days when modernization theory was ascendant. However, since the 1970's, much emphasis has been placed on moving away from frameworks that were too province-centred in outlook and interventionist in strategy. During the 1990's, various experiments in regionalization further reinforced such an approach and created some confusion about the proper role of the provincial state.

The fundamental problem in Newfoundland and Labrador is that even with the infusion of billions of dollars from oil and gas, government has far more important priorities within the health sector than wait list management and reform. Besides, given the power and influence of the interests that manage each silo and region, it would be difficult to fight the battle for reform on so many fronts, and then turn the ship around. As long as the system remains sustainable, it would be easier, politically speaking, to maintain the status quo and continue to respond reactively to emergency situations than invest fiscal and health human resources to re-make the system into one based on logic and need. Certainly the addition of new equipment will aid in reducing wait times for specific medical procedures. But unless or until the province is seriously willing to commit the necessary resources to establish a management system, intervene in areas currently under

doctor's control, province-centre waiting list reform will not likely be a top political priority in Newfoundland and Labrador.

In the end, in order for change to occur a number of things will be required. First, there need to be a sense of political crisis and sustained push for new ways of thinking and operating. To date, there appears to be little evidence of a political crisis over waiting list management in Newfoundland, or at least critics have been unable to achieve the intellectual breakthroughs necessary for change or contest the power and autonomy of the old regime in a way that would make a difference. Informal changes have occurred in areas where there has been pressure for change, for example, cardiac care and St. John's. External shocks have failed to disturb embedded governance practices and reform initiatives have tended to reinforce current boundaries and sources of power within the health care system.

Conclusion

Clearly Newfoundland and Labrador is a "no go" decision with respect to a formalized system of wait list management and tracking of patients. However, for certain medical procedures, in particular cardiac care, physicians have been able to manage demand on the health system without resorting to formal structures and mechanisms. These powerful interests have had little reason to push for more fundamental change. While some respondents expressed a sincere desire to have published wait times for procedures available to the public, the fiscal reality of the province serves as a powerful deterrent. In addition, embedded governance practices and traditions have also likely worked against any calls for a more formal, province-centred model of waiting list reform.

Governments, regardless of their ideological stripes, have other more pressing health priorities than establishing formal structures to manage wait lists and consolidate power. Much of the responsibility has been handed down to the former Health Care Corporation of St. John's but no additional funds have been provided save in the case of the recent pilot project.

In the case of Newfoundland and Labrador, one can conclude that "one size does not fit all" when it comes to managing wait lists. With its small population, poor fiscal capacity, limited number of physicians and specialists and tertiary medical care confined to the capital region, it may simply be too expensive to create a formalized system from scratch. Instead, it might be more feasible for decision makers and administrators to allow physicians in concert with the ERIHA to establish cross-service wait lists to abolish the silo effect that is currently in place. While not in the same ball park as Alberta, Newfoundland has improved its wait times for some medical and diagnostic procedures despite the barriers to reform that remain in place.

APPENDIX 1 CODING REPORT FOR WAIT LIST REFORM: NEWFOUNDLAND AND LABRADOR

REPORT ON NODES FROM Tree Nodes '~/'
Depth: ALL
Restriction on coding data: NONE

(1) /Ideas
(1 1) /Ideas/market
(1 2) /Ideas/urban
(1 3) /Ideas/collaboration
(1 4) /Ideas/doctors
(1 7) /Ideas/fiscal
(1 9) /Ideas/Reactive thinking by decision-makers
(1 11) /Ideas/priority setting
(1 22) /Ideas/Newfoundland political culture
(1 33) /Ideas/Alberta reforms
(1 34) /Ideas/Ontario reforms
(1 35) /Ideas/Crisis in wait list management
(1 42) /Ideas/Fairness in wait list management
(1 43) /Ideas/Fair access to wait listed medical and hospital services
(1 45) /Ideas/Perception among the public that there is a problem with wait lists
(1 47) /Ideas/Reform as a means of reducing wait times
(1 49) /Ideas/Quality of information to determine wait list reform
(1 51) /Ideas/Quality of evidence used in decision-making
(1 52) /Ideas/Ideas about reform
(1 55) /Ideas/Quality of data used to determine nature of reforms
(1 58) /Ideas/Funding models for wait list reform
(2) /Interests
(2 1) /Interests/Interests of patients with respect to wait list reform
(2 2) /Interests/urban
(2 3) /Interests/External factors affecting wait list reform
(2 4) /Interests/Rural interests
(2 5) /Interests/human resources
(2 6) /Interests/Physcians' interests and wait list reform
(2 7) /Interests/doctors
(2 8) /Interests/Mass media influences on wait list reform
(2 9) /Interests/nurses
(2 10) /Interests/Cardiac surgery wait lists
(2 11) /Interests/Informal networks of physicians determining lists
(2 13) /Interests/Consequences of not establishing wait lists
(2 14) /Interests/Demand for medical services
(2 15) /Interests/Priorizing services for wait list management
(2 16) /Interests/Need for wait listed medical services versus demand
(2 19) /Interests/MRI capability and access

(2 27) /Interests/Pressure for wait list reforms
(2 28) /Interests/Changes in public opinion
(2 30) /Interests/Poverty and wait list reform
(2 31) /Interests/Poor people
(2 32) /Interests/Network of health professionals
(2 36) /Interests/Advocacy groups for reform
(2 37) /Interests/Medical practitioners and reform
(2 40) /Interests/Agenda for reform
(2 41) /Interests/Wait lists
(2 44) /Interests/Control of wait lists
(2 48) /Interests/Quality of wait listing services
(2 54) /Interests/Technological changes precipitating reform
(2 59) /Interests/Policy with respect to reform
(2 62) /Interests/Lobbying for change
(3) /Institutions
(3 1) /Institutions/urban
(3 2) /Institutions/Management of wait lists
(3 3) /Institutions/external factors
(3 5) /Institutions/government structures federal and provincial
(3 7) /Institutions/funding for wait list reforms
(3 12) /Institutions/Regional Health Boards
(3 17) /Institutions/Management tools for wait list reforms
(3 17 18) /Institutions/Management tools for wait list reforms/management tool
(3 20) /Institutions/Fiscal resources for wait list reform
(3 20 24) /Institutions/Fiscal resources for wait list reform/Budgeting for wait list reform
(3 21) /Institutions/Politics and political activity
(3 23) /Institutions/Board CEOs and wait list reform
(3 25) /Institutions/Canada government and politics
(3 26) /Institutions/Tertiary care in the health system
(3 29) /Institutions/Minister of Health and Community Services
(3 38) /Institutions/Role of managers in wait list reform
(3 39) /Institutions/Coordination of groups for wait list management
(3 46) /Institutions/Booking decisions for wait listed services
(3 50) /Institutions/Money for wait list reform
(3 53) /Institutions/Resource management
(3 56) /Institutions/Resource allocation
(3 60) /Institutions/Role of hospitals in wait list reform
(3 61) /Institutions/Regionalization

APPENDIX 2 WAIT LIST MANAGEMENT AND REFORM CODING TABLES

NOTES ON TABLES AND METHODOLOGY

The terms employed for the tables are drawn from the coding report found in Appendix 1. Codes were devised based on the template from 21 October 2003 (revised) and the report distributed to the research team by John Lavis (23 November 2004). Tables are listed numerically as follows: prefix 1 are ideas; prefix 2, interests; prefix 3, external factors and prefix 4, institutions. The percentage figure in the column "# of mentions" refers to the percentage of all text units analyzed that the concept represents. For our case, there were a total of 3765 text units employed in the analysis.

TABLE 1.1 ROLE OF MARKET IDEAS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	1	100
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		1 (0.03%)	100

TABLE 1.2 REFORM IN URBAN AREAS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	8.3
2	RHA	2	16.6
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	2	16.6
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	2	16.6
10	Health Professional	0	0
11	Health Professional	5	41.7
TOTAL		12 (0.3%)	99.8

TABLE 1.3 COLLABORATION AMONG STAKEHOLDERS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	1	50
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	50
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		2 (0.05%)	100

TABLE 1.4 ROLE OF DOCTORS IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	11	25.6
2	RHA	12	27.9
3	RHA	4	9.3
4	Politician	1	2.3
5	Civil Servant	3	6.9
7	Interest Group	2	4.6
8	Civil Servant	0	0
9	Interest Group	5	11.6
10	Health Professional	2	4.6
11	Health Professional	3	6.9
TOTAL		43 (1.14%)	99.7

TABLE 1.5 FISCAL PRESSURE FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	4	80
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	20
TOTAL		5 (0.13%)	100

TABLE 1.6 PRIORITY SETTING FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	1	20
3	RHA	1	20
4	Politician	1	20
5	Civil Servant	2	40
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		5 (0.13%)	100

TABLE 1.7 POLITICAL CULTURE AND REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	1	100
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		1 (0.03%)	100

TABLE 1.8 CRISIS IN WAIT LIST MANAGEMENT

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	1	33.3
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	1	33.3
10	Health Professional	0	0
11	Health Professional	1	33.4
TOTAL		3 (0.08%)	100

TABLE 1.9 FAIRNESS IN WAIT LIST MANAGEMENT

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	2	28.6
2	RHA	2	28.6
3	RHA	1	14.3
4	Politician	1	14.3
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	14.3
TOTAL		7 (0.18%)	100.1

TABLE 1.10 FAIR ACCESS TO WAIT LISTED SERVICES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	5	19.2
2	RHA	14	53.8
3	RHA	0	0
4	Politician	2	7.7
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	1	3.8
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	4	15.4
TOTAL		26 (0.69%)	99.9

TABLE 1.11 PUBLIC PERCEPTION WAIT LIST PROBLEMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	2	66.7
5	Civil Servant	1	33.3
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		3 (0.08%)	100

TABLE 1.12 REDUCING WAIT TIMES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	50
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	50
TOTAL		2 (0.05%)	100

TABLE 1.13 REACTIVE THINKING TO REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	1	100
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		1 (0.03%)	100

TABLE 1.14 REFORM AS A MEANS OF REDUCING COSTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	100
TOTAL		1 (0.03%)	100

TABLE 1.15 QUALITY OF INFORMATION FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	33.3
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	2	66.7
TOTAL		3 (0.08%)	100

TABLE 1.16 REFORM AND QUALITY OF CARE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	2	100
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		2 (0.05%)	100

TABLE 1.17 QUALITY OF EVIDENCE USED IN DECISION-MAKING

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	8	57.1
2	RHA	1	7.1
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	5	35.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		14 (0.4%)	99.9

TABLE 1.18 QUALITY OF DATA USED FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	33.3
2	RHA	1	33.3
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	33.4
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		3 (0.08%)	100

TABLE 1.19 FUNDING MODELS FOR WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	7	58.3
2	RHA	0	0
3	RHA	3	25
4	Politician	1	8.3
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	8.3
TOTAL		12 (0.32%)	99.9

TABLE 2.1 INTERESTS OF PATIENTS WITH RESPECT TO REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	21	42.9
2	RHA	6	12.2
3	RHA	3	6.1
4	Politician	2	4.1
5	Civil Servant	2	4.1
7	Interest Group	2	4.1
8	Civil Servant	0	0
9	Interest Group	2	4.1
10	Health Professional	0	0
11	Health Professional	11	22.4
TOTAL		49 (1.3%)	100

TABLE 2.2 RURAL INTERESTS IN WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	3	15.8
2	RHA	1	5.3
3	RHA	4	21.1
4	Politician	2	10.6
5	Civil Servant	4	21.1
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	5	26.3
TOTAL		19 (0.5%)	100.2

TABLE 2.3 HUMAN RESOURCES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	1	20
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	1	20
9	Interest Group	2	40
10	Health Professional	1	20
11	Health Professional	0	0
TOTAL		5 (0.13%)	100

TABLE 2.4 MEDIA INTEREST IN WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	4	33.3
4	Politician	0	0
5	Civil Servant	3	25
7	Interest Group	3	25
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	2	16.7
11	Health Professional	0	0
TOTAL		12 (0.3%)	100

TABLE 2.5 INTERESTS OF NURSES IN WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	1	50
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	1	50
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		2 (0.05%)	100

TABLE 2.6 CARDIAC SURGERY AND WAIT LISTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	8	11.3
2	RHA	12	16.9
3	RHA	18	25.3
4	Politician	5	7
5	Civil Servant	5	7
7	Interest Group	13	18.3
8	Civil Servant	0	0
9	Interest Group	2	2.8
10	Health Professional	0	0
11	Health Professional	8	11.3
TOTAL		71 (1.9%)	99.9

TABLE 2.7 INFORMAL NETWORKS OF PHYSICIANS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	4	100
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		4 (0.11%)	100

TABLE 2.8 CONSEQUENCES OF NOT ESTABLISHING WAIT LIST SYSTEM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	25
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	25
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	25
11	Health Professional	1	25
TOTAL		4 (0.11%)	100

TABLE 2.9 DEMAND FOR MEDICAL SERVICES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	8	25.8
2	RHA	8	25.8
3	RHA	1	3.2
4	Politician	0	0
5	Civil Servant	1	3.2
7	Interest Group	1	3.2
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	7	22.6
11	Health Professional	5	16.1
TOTAL		31 (0.8%)	99.9

TABLE 2.10 PRIORIZING MEDICAL SERVICES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		1 (0.03%)	100

TABLE 2.11 NEED VERSUS DEMAND FOR MEDICAL SERVICES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	15	40.5
2	RHA	13	35.1
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	2.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	2	5.4
11	Health Professional	6	16.2
TOTAL		37 (1.0%)	99.9

TABLE 2.12 MRI ACCESS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	4	22.2
2	RHA	0	0
3	RHA	0	0
4	Politician	2	11.1
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	1	5.6
10	Health Professional	0	0
11	Health Professional	11	61.1
TOTAL		18 (0.5%)	100

TABLE 2.13 PRESSURE FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	3	9.1
2	RHA	10	30.3
3	RHA	6	18.2
4	Politician	3	9.1
5	Civil Servant	0	0
7	Interest Group	5	15.2
8	Civil Servant	0	0
9	Interest Group	1	3
10	Health Professional	0	0
11	Health Professional	5	15.2
TOTAL		33 (0.88%)	100.1

TABLE 2.14 NETWORK OF HEALTH PROFESSIONALS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	4	80
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	20
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		5 (0.13%)	100

TABLE 2.15 ADVOCACY GROUPS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	2	50
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	2	50
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		4 (0.11%)	100

TABLE 2.16 MEDICAL INTERESTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	2	20
2	RHA	3	30
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	2	20
7	Interest Group	1	10
8	Civil Servant	0	0
9	Interest Group	1	10
10	Health Professional	0	0
11	Health Professional	1	10
TOTAL		10 (0.27%)	100

TABLE 2.17 AGENDA FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	3	42.9
2	RHA	1	14.3
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	14.3
7	Interest Group	2	28.6
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		7 (0.19%)	100.1

TABLE 2.18 INTEREST IN WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	3	6
2	RHA	12	24
3	RHA	16	32
4	Politician	7	14
5	Civil Servant	1	2
7	Interest Group	6	12
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	3	6
11	Health Professional	2	4
TOTAL		50 (1.3%)	100

TABLE 2.19 CONTROL OF WAIT LISTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	1	100
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		1 (0.03%)	100

TABLE 2.20 TECHNOLOGICAL CHANGE DRIVING REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	1	50
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	50
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		2 (0.06%)	100

TABLE 2.21 LOBBYING FOR CHANGES TO WAIT LISTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	5	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		5 (0.13%)	100

TABLE 3.1 ALBERTA REFORMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	7	58.3
3	RHA	2	16.7
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	3	25
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		12 (0.32%)	100

TABLE 3.2 ONTARIO REFORMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	16.7
2	RHA	0	0
3	RHA	2	33.4
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	16.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	2	33.4
TOTAL		6 (0.16%)	100.2

TABLE 3.3 GOVERNMENT OF CANADA

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	5	62.5
2	RHA	0	0
3	RHA	0	0
4	Politician	1	12.5
5	Civil Servant	2	25
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		8 (0.21%)	100

TABLE 3.4 EXTERNAL FACTORS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	25
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	25
7	Interest Group	1	25
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	25
11	Health Professional	0	0
TOTAL		4 (0.11%)	100

TABLE 3.5 ROMANOW INFLUENCES ON REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	1	33.3
5	Civil Servant	0	0
7	Interest Group	2	66.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		3 (0.08%)	100

TABLE 4.1 MANAGEMENT OF WAIT LISTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	3	15
2	RHA	3	15
3	RHA	2	10
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	2	10
10	Health Professional	0	0
11	Health Professional	10	50
TOTAL		20 (0.53%)	100

TABLE 4.2 FUNDING FOR WAIT LIST REFORMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	7	63.6
2	RHA	0	0
3	RHA	3	27.3
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	9.1
TOTAL		11 (0.3%)	100

TABLE 4.3 REGIONAL HEALTH BOARDS AND REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	7.1
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	12	85.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	7.1
TOTAL		14 (0.37%)	99.9

TABLE 4.4 MANAGEMENT TOOLS FOR WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	3	25
2	RHA	5	41.7
3	RHA	1	8.3
4	Politician	0	0
5	Civil Servant	2	16.6
7	Interest Group	1	8.3
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		12 (0.32%)	99.9

TABLE 4.5 FISCAL RESOURCES FOR WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	3	75
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	25
TOTAL		4 (0.11%)	100

TABLE 4.6 BUDGETS AND BUDGETING FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	4	18.2
2	RHA	0	0
3	RHA	0	0
4	Politician	7	31.8
5	Civil Servant	0	0
7	Interest Group	8	36.4
8	Civil Servant	1	4.5
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	2	9
TOTAL		22 (0.6%)	99.9

TABLE 4.7 TERTIARY CARE AND WAIT LISTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	3	30
4	Politician	2	20
5	Civil Servant	0	0
7	Interest Group	1	10
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	4	40
TOTAL		10 (0.27%)	100

TABLE 4.8 MINISTER AND DEPUTY MINISTER OF HEALTH

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	2	22.2
4	Politician	0	0
5	Civil Servant	1	11.1
7	Interest Group	1	11.1
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	5	55.6
TOTAL		9 (0.24%)	100

TABLE 4.9 ROLE OF RHA MANAGERS IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	33.3
2	RHA	2	66.7
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		3 (0.08%)	100

TABLE 4.10 BOOKING DECISIONS FOR MEDICAL PROCEDURES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	3	60
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	20
8	Civil Servant	0	0
9	Interest Group	1	20
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		5	100

TABLE 4.11 MONEY FOR WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	15	29.4
2	RHA	6	11.8
3	RHA	6	11.8
4	Politician	6	11.8
5	Civil Servant	1	2
7	Interest Group	5	9.8
8	Civil Servant	0	0
9	Interest Group	2	3.9
10	Health Professional	2	3.9
11	Health Professional	9	17.6
TOTAL		51 (1.35%)	102

TABLE 4.12 RESOURCE MANAGEMENT

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	0	0
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		1 (0.03%)	100

TABLE 4.13 RESOURCE ALLOCATION

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	0	0
2	RHA	1	100
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	0	0
TOTAL		1 (0.03%)	100

TABLE 4.14 ROLE OF HOSPITALS IN WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	4	19
2	RHA	3	14.3
3	RHA	4	19
4	Politician	2	9.5
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	1	4.8
9	Interest Group	1	4.8
10	Health Professional	0	0
11	Health Professional	6	28.6
TOTAL		21 (0.56%)	100

TABLE 4.15 REGIONALIZATION AND WAIT LIST REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
1	RHA	1	9.1
2	RHA	4	36.4
3	RHA	4	36.4
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	9.1
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
11	Health Professional	1	9.1
TOTAL		11 (0.3%)	100.1