

Managing Wait Times in Saskatchewan
Tom McIntosh, Michael Ducie
And Courtney England

1) Introduction

Wait times and related issues of access to necessary health care services continues to be one of the key concerns of governments, health system managers, health professionals of all types, policy analysts and, of course, the general public. The September 2004 meeting of First Ministers in Ottawa made reducing wait times for key surgical diagnostic procedures a priority for governments and the federal government offered significant funds to the provinces to continue their work on managing and reducing the wait-times for patients in those areas. In Saskatchewan, this has contributed to further implementation and development of the Saskatchewan Surgical Care Network, \$1.3 million of the \$3.8 million budget came from the Federal government as a result of the First Minister's meeting.¹

Yet the move to tackle wait-times should not be seen as a top-down process being driven in the main by political actors. The First Ministers commitment of both funding and attention to the issue came at a time when jurisdictions across the country were already implementing wait-time reduction strategies that were themselves the culmination of sometimes years of detailed study and analysis of the complex range of factors that can contribute to unacceptably long waits for necessary surgical and other medical (usually diagnostic) procedures.

This case study is concerned with the decisions that led to the creation of the Saskatchewan Surgical Care Network (SSCN) – an integrated web-based tool designed to provide patients with reasonably sound estimates of their expected wait times for specific

¹ Saskatchewan Health Annual Report 2004 – 2005, p. 16

surgical procedures² and provide physicians with a series of protocols for the standardized assessment of patients by physicians and the allocation of surgical time by hospitals. As the SSCN evolved it incorporated benchmarks for wait times for categorized surgical or diagnostic procedures, patients can see where they are on the list but must contact the surgical coordinator for their health district who will give a reasonably firm estimate of how long they may be waiting for a procedure given their specific degree of severity. As is evident below, the eventual rolling out of the SSCN in July, 2003 was the culmination of a number of previous interventions (both successful and unsuccessful) to manage wait lists and reduce wait times in the province.

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

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

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

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

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

The network also sponsors a website that "provides general information about how many specialists there are in each of the health regions to do specific types of procedures. It also lists their credentials to help patients make informed decisions."⁴ More recently, the network has developed a patient assessment process which includes six prioritization levels with corresponding target wait times for each. Patients are prioritized as their surgeon sees them by being rated by point-count measures according to level of pain, the potential of the condition to worsen and the ability of the patient to function at work and at home. Total point counts can range between one and one hundred. A higher number indicates a more urgent need for surgery. For example, the

³ Saskatchewan Surgical Care Network. "About the SSCN" [<http://www.sasksurgery.ca/about-SSCN.html>].

⁴ Driver, Deanna. "Saskatchewan Site Makes Sense of Waiting Lists." The Medical Post February 4, 2003. Vol 39. No. 5.

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

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

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

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

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

⁵ 12WLSK

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

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

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

⁶ 03WLSK

⁷ 01WLSK

public waiting for surgery but also in the aggregate insofar as surgical volumes are important for planning purposes at the hospital, regional health authority and the provincial level. Accurate information becomes, therefore, a basic cornerstone for insuring (or perhaps reinforcing) confidence in the overall performance of the system.

The second goal was to use the information to create the centralized surgical registry itself. In the words of one of the interviewees, the government had: "then to turn around and get that registry and prioritize patients on that list so that you know that those that are the most urgent or the highest priority are receiving the service soonest, and those that are waiting the longest are the most appropriate to wait."⁸ While the third goal was to set targets for surgical wait times that were based on severity of need and achievable with ninety percent accuracy (i.e. the target had to be met for 90% of the patients). In May of 2004, the SSCN announced the establishment of Target Time Frames for Surgery; this represented performance goals for the surgical system based on assessments of patients and the application of a score based on their condition and urgency, this score would then correspond to a priority level giving the patients an indication of their need for surgery.⁹

Setting targets would then allow the government to achieve a fourth goal – the targeting of resources within the surgical system in a manner that could be counted on to achieve specific results. In the words of one interviewee: "Once you have [targets] established you want to be able to add incremental resources and measure the output immediately."¹⁰ In May of 2004, the Enews for the SSCN stated that "once the [surgical patient] registry is fully operations across the province, it will greatly improve the

⁸ 04WLSK

⁹ <http://www.gov.sk.ca/news?newsId=92855237-ad73-463c-a5ed-2c43bf737ed6&newsPN=Shared>

¹⁰ 04WLSK.

surgical care system's ability to predict who needs surgery, and the time frame within which it should be done. *This will promote the best possible use of resources and system capacity, and will ultimately result in reduced waiting times for patients.*"(Emphasis added)¹¹ The final goal was the dissemination of information to the public in a manner that was easily accessible and understandable. This would allow government to reassure individuals about "how long you could expect to wait, how the procedure works, it is a system and not just a random act to try and get in for surgery, it's not based on who you know or how loudly your physician screams, you're going to be seen based on a set, an objective set, of criteria."¹² This has been achieved through the SSCN website (www.sasksurgery.ca). Here, a patient can go and learn how many people are on the waiting list in their specific surgery category, see how the criteria for patient priority is established, and the current statistics regarding time frames for completion of surgical procedures, and, learn about the genesis and development of the surgical patient registry (through E-news, the SSCN publication), and can login to find out where they are on the waiting list.

Waiting List Reports

In the decade preceding the establishment of the SSCN wait lists and wait times had been one of the most contentious and controversial aspects of the ongoing health care debate. Studies indicating growing wait times in specific surgical areas and for advanced diagnostic testing were, in the minds of the public and many politicians, increasingly cited as a key indicator of a system in crisis. Regardless of their source they all have roughly the same message: that surgical wait lists across Canada are too long. All

¹¹ <http://www.gov.sk.ca/news?newsId=92855237-ad73-463c-a5ed-2c43bf737ed6&newsPN=Shared>

¹² 04WLSK

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

The Fraser Institute report is a result of a survey of the opinions of Canadian physicians' regarding wait lists and waiting times in Canadian provinces. Waiting times indicated in the report are often generalized from few survey responses, thus making the report largely scientifically unsound. One participant affiliated with a Regional Health Authority "felt that Fraser was detracting from a solution by creating false messages and that somehow we had to be able to better understand wait list issues if we were going to counteract what Fraser was doing on an annual basis."¹³

The report "generated a lot of government concern relative to Saskatchewan because we looked like we had the biggest lists and the longest lists...in the country...Government was very concerned about that."¹⁴ A civil servant who's work was once concentrated on wait lists indicated that the Fraser report (combined with calls from the public) drove government to look at wait lists with a little more effort.¹⁵

While many noted that the methodological inadequacies of the report made it a real non-issue for policy-makers and academics, the media accepted it "as gospel."¹⁶ The media reports of Fraser kept "the issue of waiting lists in the public and politicians

¹³ 05WLSK

¹⁴ 01WLSK

¹⁵ Ibid.

¹⁶ Ibid.

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

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

Another significant report in the wait list policy reform process is the Health Canada Report Released in 1998: Waiting Lists and Waiting Times for Health Care in Canada: More Management, More Money? An academic participant in our study described this document to have "basically set the foundations of the work that followed which showed that wait lists were poorly managed."²⁰ This report did not share the same media attention or governmental action as the Fraser reports. However, the report also did not point a finger at specific regions with longer waiting times. The Health Canada report simply "showed that wait lists were inconsistently managed and measured...dead

¹⁷ 05WLSK.

¹⁸ 03WLSK.

¹⁹ 05WLSK.

²⁰ 02WLSK.

people on the list, those kind of things. It was basically a literature review and analysis of any...or a summary of any analysis that had been done across the country on waiting lists to date."²¹

The Health Services Utilization and Research Commission (HSURC), based in Saskatchewan, was involved as a collaborator in this report. Given that HSURC was an arm's length agency funded by Government which was directed to report to the Minister of Health the results of any research and findings, the Government of Saskatchewan would have been kept well aware of the policy issue. One participant, who was closely associated with HSURC at the time, identified this Health Canada report as a key factor in the decision to join the Western Canada Waiting List Project.²²

Almost immediately following the Health Canada report, the Saskatchewan Government made two crucial moves in the evolution of waiting list policy in the province. Both show a commitment on the part of government to address long wait times; a problem which both the Fraser Institute and the Health Canada Reports address as a growing one. In the first instance, government commissioned the Task Team on Surgical Waiting Lists to "describe a fair and transparent system for scheduling elective surgical procedures" and to "recommend the steps necessary to implement the waiting list system across the province."²³ Secondly, Saskatchewan joined the Western Canada Waiting List Project (WCWL) which "designed tools for the purpose...[of creating] an

²¹ Ibid.

²² 02WLSK

²³ Pat Atkinson, Minister of Health. Quoted in: [<http://www.gov.sk.ca/newsreel/releases/1998/12/02-892.html>]

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

The task team included Dr. Stewart McMillan; Dr. Barry Maber, Vice President of Physicians at the Saskatoon Health District; and Dr. Mark Ogrady, Head of Surgery for the then Regina Health District.²⁵ Government had practical reasoning behind using only physicians on this team: the "team has first-hand knowledge of the way surgery is managed now, and they can lead us toward practical solutions."²⁶ The task team had two clear principle objectives: "(i) describe a fair and transparent system for scheduling elective surgical procedures (i.e. a waiting list system); and (ii) recommend the steps necessary to implement the waiting list system across the province."²⁷

The final report, submitted on March 17 of 1999 made 23 recommendations. The recommendations can be grouped into 6 categories:

- ❑ provide funding for additional surgical equipment and more operating room hours;
- ❑ change systems so that physicians can assign priority to elective surgery patients according to medical conditions;
- ❑ coordinate 24 hour post-operative care into districts surrounding Regina and Saskatoon;
- ❑ serve more patients through day surgery and do more procedures through alternate ambulatory care settings instead of in operating rooms;
- ❑ inform patients about their options and how surgical waiting lists operate; and
- ❑ establish a committee to oversee improvements, review problem areas and monitor the system.²⁸

The Minister of Health at the time, Pat Atkinson, promised on March 17, 1999 that the recommendations would be answered, and within a timely manner they were

²⁴ 09WLSK.

²⁵ [<http://www.gov.sk.ca/newsreel/releases/1998/12/02-892.html>]

²⁶ Pat Atkinson, Minister of Health. Quoted in: [<http://www.gov.sk.ca/newsreel/releases/1998/12/02-892.html>]

²⁷ Ibid.

²⁸ [<http://www.gov.sk.ca/newsreel/releases/1998/12/02-892.html>]

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

However, "throwing the money at it...didn't create the solution [government was] looking for."²⁹ According to one participant active in the research community, the thinking behind such a program was that by buying our way out, waiting lists would disappear in a matter of a few years.³⁰ As became evident in the years that followed, the strategy had little long term impact on the overall size of the wait lists in the districts receiving the funds or on the median wait times within those districts. "What ended up happening is when it came time for the wait list initiative and they started buying volume, what they didn't do is they didn't have control over the overall allocation so if you pour five million dollars into a surgical fund – into a health district in those days – and they

²⁹ 04WLSK.

³⁰ 02WLSK.

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

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

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

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

³¹ 04WLSK.

³² Ibid.

³³ 02WLSK

questions and the methodology are not...rocket science ... they're not anything breathtakingly new. What they are is basically...a distillation onto paper of the process that most people go through implicitly and now the WCWL and the SSCN are trying to make it more explicit and by introducing a quantitative scoring process to ...introduce some sort of consistency between different surgeons which is the huge issue of course.³⁴

What the WCWL did, according to one participant, was to provide clear information to the public about waiting times. While waiting lists as a political issue was constantly being thrown at government,

they didn't have clear information, they didn't have a solid registry, they didn't have the tools for prioritization, they didn't have targets that were set, when many other jurisdictions across the world were attempting to set targets. And the gap for the politicians was that the public didn't have what they needed. Some of it was that they just didn't understand how long they might have to wait for a particular procedure.³⁵

By joining the WCWL, Saskatchewan had a better chance of getting all of these things that they didn't have. Clear information would allow government to reach their goals of consistency and transparency,

While most participants agreed that the WCWL tools were useful in waiting list management, some participants were more cautious in their approach. One might expect that physicians would be more skeptical of the assessment tools insofar as they could be viewed as a means to substitute a 'bureaucratic' instrument for an individual physician's clinical judgment. And while there was some resistance from a small minority of physicians, and skepticism from one of the physicians interviewed who cautioned that the tools themselves may not make a significant difference in waiting times as they are

³⁴ 05WLSK

³⁵ 04WLSK

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

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

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

³⁶ 03WLSK

³⁷ 08WLSK

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

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

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

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

³⁸ 02WLSK

³⁹ 04WLSK

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

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

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

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

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

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

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

⁴¹ 01WLSK

a larger province would face greater challenges due in no small amount to the level of data to be managed.

After the Action Plan was released and the decision was made to set up some kind of wait list management system, it was "agreed right away that when we put it in place that we needed a third party and that was the first thing that we did."⁴² Health care consultant Peter Glynn was hired by the province as a third party to head the process. Glynn's role was particularly important in eyes of one interviewee insofar as he came with years of expertise in the health care system⁴³ and a degree of independence that would insulate him from any pressures from either government or stakeholder sources.⁴⁴

The Action Plan's call for a more comprehensive plan for wait list management was contained in a subsequent report entitled *Surgical Wait List Management: A Strategy for Saskatchewan* that was released in January, 2002. Among the nine recommendations was the call for an electronic surgical registry in Saskatchewan, the development of priority criteria tools and the designation of a surgical services coordinator to allow for communication between the district, the patient and the physician. These ideas were eventually moulded into the Saskatchewan Surgical Care Network (SSCN).

While the SSCN was the next step in the *policy* evolution from the Wait List Funding Initiative (WLFI), it had few characteristics in common. Where the WLFI focused on a single policy lever – the transfer of one time funding to increase surgical capacity and thereby hopefully reduce wait lists – the SSCN was a larger, more complex and multi-faceted approach. And it is clearly more reflective of the kind of approach

⁴² 12WLSK

⁴³ Peter Glynn was President and CEO of the Kingston General Hospital. Before that he was Assistant Deputy Minister of the Health Services and Promotion Branch of Health and Welfare Canada. Prior to that, he was the Associate Deputy Minister of Saskatchewan Health

⁴⁴ Ibid.

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

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

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

Interjurisdictional Learning

⁴⁵ 07WLSK.

While waiting list policy evolved as government learned from its own research and experiences, it must also be noted that government learned from other jurisdictions. The most obvious example is the province's participation in the WCWL work in collaboration with other provinces, health authorities and stakeholder groups. As part of its own work the WCWL made a conscious decision to survey both the domestic and international scene for an understanding of the processes being developed beyond western Canada. Ontario's experience with the Cardiac Care Network was repeatedly cited as a key inspiration not only for the work of the WCWL but within the Saskatchewan Department of Health during the development of the SSCN. As Macdonald et al. have noted: "Ontario had adopted a multi-pronged approach to waiting lists for selected procedures, with a primary focus of cardiac care."⁴⁶ In the view of one interviewee, the Cardiac Care Network, though voluntary "was ...the first Canadian prototype of a priority driven system for booking patients."⁴⁷ The network is comprised of surgical centres

performing catheterization and angioplasty procedures in addition to...cathing centres. Each centre has a nurse coordinator who is responsible for collecting relevant data for each patient as well as locating a suitable and willing surgeon or interventional cardiologist who will then communicate directly with the referring physicians. The registry, therefore, is used to actively manage patients, providing relevant patient information to clinicians as well as providing information regarding physician availability to patients.⁴⁸

⁴⁶ McDonald, Paul; Shortt, Sam; Sanmartin, Claudia; Barer, Morris; Lewis, Steven and Sheps, Sam. Waiting Lists and Waiting Times for Health Care in Canada: More Management!! More Money?? June 1998. P. 299.

⁴⁷ 05WLSK.

⁴⁸ Ibid.

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

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

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

⁴⁹ McDonald et al. p. 293.

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² 03WLSK.

information technology infrastructure for the network Saskatchewan eventually purchased software developed for the NHS' own wait list management initiatives.⁵³

At the second national symposium on wait list management progress, billed as Taming of the Queue II, held in Ottawa in 2005, symposium co-chair David Naylor noted a direct evolutionary line from the Cardiac Care Network to the WCWL to the SSCN and back to Ontario's recently announced Access to Services and Wait Time Strategy. This is evidence, in his view, of an increased willingness of Canadian jurisdictions to share successes (and cautionary tales) and adapt those learnings to their own specific needs. It was not only the knowledge gained from other jurisdictions that help to form the SSCN, but also the combination of interests involved in the process.

While much of the inspiration for the SSCN – as well a significant proportion of the intellectual heavy-lifting – stemmed from work that occurred outside the government of Saskatchewan, there was a clear consensus amongst the interviewees that the transformation of those ideas into specific policy prescriptions was the result, again, of specific champions within the Saskatchewan civil service. Time and again subjects noted the work undertaken by the leadership within the Acute and Emergency Services Branch of the government that convinced the government that the SSCN was the most viable option for a longer term solution to the wait list problems facing the province.⁵⁴ And it was these individuals that kept the process on track despite the fact that the option chosen was complicated, involved some level of resistance from stakeholders and would likely take a long time (at least in political terms) to yield concrete and measurable results.⁵⁵

⁵³ 12WLSK.

⁵⁴ 04WLSK, 07WLSK.

⁵⁵ 07WLSK

It is interesting to note that although some actors within the health system were less than enthusiastic about the SSCN, there was little in the way of organized opposition from stakeholders, especially physicians. One SMA staffer did not “recall the SMA having any meaningful input into the design of [the SSCN].”⁵⁶ This same participant noted that while many policies that came out of Saskatchewan Health are perceived to have an anti-physician bias, the “SSCN is probably one that’s kind of neutral.”⁵⁷ It might also be instructive to note again that the traditional physician response to wait lists was to argue for more resources to increase capacity. But that strategy had clearly failed to produce lasting results under the WLFI and, without the proper management of wait lists, it was impossible to know where exactly to target those resources or even to insure that new dollars allocated to health districts were being spent on increasing surgical capacity. Despite the prospect that the SSCN would have some impact on how physicians and surgeons practiced medicine, the SMA remained officially neutral on its appropriateness, design and implementation processes.⁵⁸ This may have been due to their own inability to articulate a workable alternative to the government’s plans beyond calling for more money for more surgeries.

At the same time, there were, as noted above, physician-champions for the SSCN both in its developmental and implementation stages that proved willing to expend personal capital in selling the solution to their fellow physicians and demonstrating that it would over time become a positive innovation in the way they practiced medicine. Indeed in the same way that some individuals outside of government point to specific government officials as the key movers behind the SSCN from idea to drawing board to

⁵⁶ 13WLSK.

⁵⁷ Ibid.

⁵⁸ 12WLSK.

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

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

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

⁵⁹ 12WLSK.

⁶⁰ 04WLSK.

⁶¹ Ibid.

eventually left the initiative. “The College of Nursing didn’t stay with it, and the SRNA didn’t...it wasn’t their interest.”⁶²

Ideas, Interests, Institutions and External Events: The Evolution of Wait List Policy in Saskatchewan

Surgical waiting lists have become an important policy issue in all Canadian provinces. In Saskatchewan, this had meant an evolution with respect to wait list policy. In its first iteration, the government defined the issue in response to both growing public concern and pressure from organized interest outside of the government. Despite the significant criticism that can be levelled at the Fraser Institute reports in terms of a less than scientifically rigorous methodology, these reports were extremely influential in driving the issue of wait times and the length of wait lists onto the political agenda. And they became a lightning rod for political action on the part of organized interests within the health care system. The media supplemented the studies with a series of so-called horror stories of individuals who had experienced or were experiencing extremely long waits for needed medical procedures. That these particular stories could not be demonstrated to be representative of wait times in the province was neither here nor there insofar as they became illustrative a health care system lurching into crisis.

Thus, it was within this context of a system falling into crisis that motivated the actions of both government and other policy actors. The problem became defined, in effect, as disequilibrium between the demand for specific services and the system’s ability to supply those services. The solution to this problem was, therefore, to increase the supply of the services through increasing resources for surgical services. This was clearly the case made at the time by the medical profession within the province and

⁶² 12WLSK.

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

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

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

Saskatoon but elsewhere in the province as well. By accepting the definition of the problem as a lack of resources within the system the government was able, consciously or unconsciously, to avoid questions of whether the problem of wait times and wait lists was illustrative of something more fundamentally wrong with the way the system organized access to key surgical and diagnostic services and how access to those services was allocated and by whom. Thus, the policy choice made by the government in this instance did not challenge any of the organized interests or institutional forces within the health system but rather sought to accommodate them by increasing the resources at their disposal.

The failure of the policy choice to make any significant or permanent change to either the length of the wait lists or the length of wait times was evidenced – at least in the minds of some – by subsequent iterations of the Fraser Institute study as well as by a number of studies carried out by the government of Saskatchewan and other researchers which are detailed above. And at the same time the political storm created by the media's continued focus on those egregious cases of individual patients waiting exceptionally long times for necessary surgery or diagnostics continued to feed into the growing public perception that the system was in crisis. Arguments by some policy analysts – and by some within the government and the bureaucracy – that sought to either discredit the Fraser Institute studies or to argue that the situation had been misdiagnosed due to the lack of reliable data (which itself pointed to the need to fundamentally change the way in which wait lists were managed) were perceived as attempts to deflect criticism of the government's failure to solve the problem.

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

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

In effect, the participation in the WCWL marked a ‘second track’ of policy development within the government. It would continue to make more or less ad hoc decisions regarding financial and human resource allocations within the system in response to specific situations (e.g. incentives for some surgeons to stay in some

communities in the province) on a case by case basis while pursuing a parallel course action couched in the language of ‘evidence-based decision-making’.

Yet there is some evidence in the interviews conducted that the government knew that the ad hoc decisions described above were at best stop-gap measures designed to lower the political heat on issues of access to certain services. The need for a more systematic approach to the issue of wait lists and wait times was taken up by the Fyke Commission which wrote approvingly of the progress being made by the WCWL and this was further emphasized in the subsequent Action Plan for Saskatchewan Health Care. The failure of the WLFI showed that simply increasing resources globally was not the answer and that without better data the government would be unable to target resources to those areas where they could have had some impact. The WCWL not only provided the province with priority criteria on which to base the SSCN tools, but also provided an inter-jurisdictional forum for the purpose of learning what other domestic and international jurisdictions have done regarding waiting lists and what has been successful for them.

In a very important sense the SSCN appears very much to have been a technocratic solution to a very political problem. Concern over wait lists – fuelled by anecdotal reporting of individual ‘horror stories’ in the media and the consistently bad grades handed out by the Fraser Institute every year – were becoming a growing headache for the provincial government. The link between growing wait lists and previous cuts to health spending at the federal level and the closure of over 50 hospitals in the early 1990s was apparent in the public’s mind, regardless of the lack of any real evidence of a causal link. The initial policy response – urged by physicians and

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

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

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

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

were in positions of influence within the bureaucracy (and were instrumental in bringing political actors on side to the proposed approach and acted as mediators between the researchers and the government) as well as within the provider community (who were prepared to expend personal political capital to demonstrate that any perceived threat to physician independence was minimal). Political support for the incremental work of the WCWL and, eventually, the SSCN was maintained, it seems, by two key factors. First, the solution advocated by provider groups – whereby they would allocate the global increases in resources as they deemed fit – had little credibility within the bureaucracy and was resisted as politically unworkable by a government concerned about containing increases to the health budget. Second, and in direct contrast to the first, ad hoc decisions concerning incentives to individual physicians or hospitals to retain necessary surgical capacity, allowed the government to buy breathing room to complete the roll-out of the SSCN.

It is still yet to be seen what will become of the SSCN but the support for its further refinement and development appears undiminished. Since inception, a number of validity studies have been done, the results of which may have helped to alleviate some of the initial concerns. Interestingly, one caution was heard from one former Saskatchewan Health official involved in the network's development. In short, the concern was expressed that the government may have overstated its accomplishments leading up to the unveiling of the registry itself and the rolling out of the website that would allow patients to check on their progress through the list. Given the still rudimentary nature of the information available there was some concern that the government was 'selling' the SSCN as a panacea and that it could quickly be discredited

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