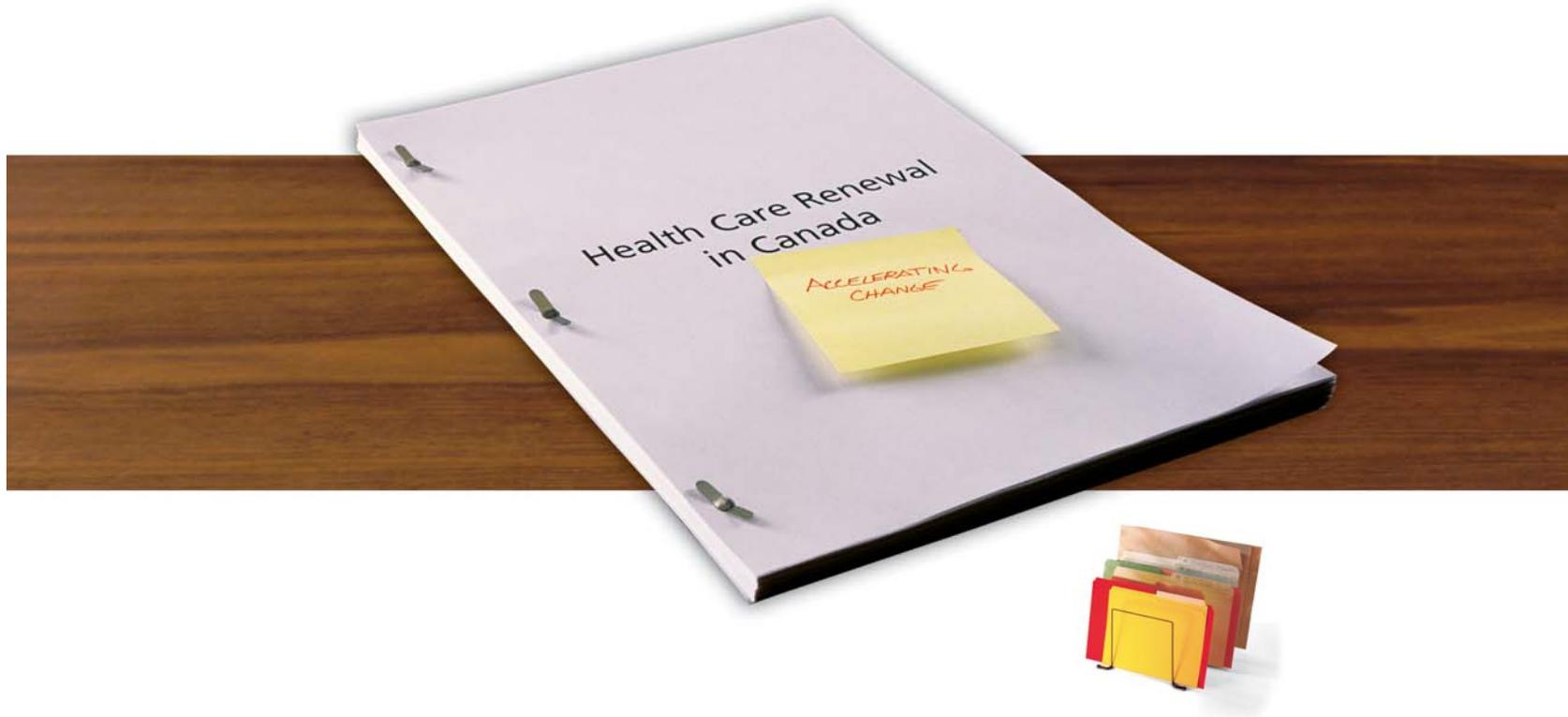


WAIT TIMES AND ACCESS

A background paper to accompany
Health Care Renewal in Canada: Accelerating Change
(January 2005)



Acknowledgements

The Health Council of Canada would like to acknowledge the following individuals for their contributions to this report. First, the members (past and present) of the Council's Working Group on Wait Times and Access: Robert McMurtry (Chair), Steven Lewis, Les Vertesi and Glenda Yeates. Lilian Bayne lent her policy expertise to the preparation of the report and Peter Glynn provided insightful comment. Lisa Maslove of the Council staff also provided support.

Please note that the information in this report was current as of November 2004.

Wait Times and Access

A background paper to accompany *Health Care Renewal in Canada: Accelerating Change* (January 2005)

Canadians have identified long waits as their number one barrier in accessing health care services. In response, at their most recent meeting (September 2004), First Ministers committed to achieving meaningful reductions in wait times for a set of priority medical procedures.

Neither the concerns nor the commitment to improvement is new. Governments as well as regional health authorities and hospitals have targeted money to improving wait times. They have added personnel, equipment and facilities. They have introduced management systems. And they have developed websites to share information with providers, patients and the public. But the issues associated with waiting for care are complex, and lasting solutions are hard to come by. The challenge is to ensure that resources dedicated to addressing the problem lead to real improvements.

This paper seeks to advance understanding of the issues surrounding timely access to quality care. It addresses the questions of why timely access is an issue; why waits occur; what has been done to improve timely access; and what we might do to overcome impediments and improve progress. We conclude with comments on how the Health Council of Canada can contribute to promoting progress in coming months and years.

1. Why is the issue of timely access important?

It is a reality that health care is not always easily accessible to those in need, particularly in remote and rural regions, in areas where providers and services are in short supply, or to populations with special needs. Even for those living in well-resourced, urban areas, there is a high level of anxiety about waiting for needed care. For good reason people are concerned about being placed on a waiting list. They know that waiting too long for care may harm your health.

Take as examples two high profile procedures – eye and joint surgery. Neither cataracts nor arthritis are usually life-threatening conditions. But, left untreated, arthritis can affect the structure and function of joints and deterioration of the muscles that control them. Poor visual acuity can lead to accidents and injury which may be disabling or even life-threatening. Timely access to care can mean the difference between active participation in the workforce, home life or leisure activities, and a spiral of increasing pain, injury, and disability.

For cancer or heart disease, delaying treatment can be even more serious. Left unchecked, malignant cancers can spread, compromising control of the cancer and leading to higher rates of complications and mortality. Heart attack victims often die before they can reach a hospital or be discharged successfully to their homes. Timely interventions can prevent premature disability and death.

In addition to physical risks, there is anxiety around the uncertainty associated with waiting for treatment. People on waiting lists are concerned about the impact of waiting on their health and recovery, about exactly when they will get care, and whether the system is fair in setting its priorities.

Waiting too long has implications for the health care system as well. Deterioration in health status while waiting for care can lead to greater care needs for patients in the long run. This cannot be good news for a system straining to meet many competing demands. With the system's ability to cope already in question, waiting for care has become a shorthand measure of system sustainability. Excessive waiting undermines public confidence in the publicly funded, publicly administered health care system.

Wait times are also a normal part of any health care system. No waiting would mean that the system is inefficient. The issue is how to manage wait lists to ensure that patients get care at the right time. Also, not all waits are harmful. Sometimes a limited amount of waiting allows the confirmation of a diagnosis or a second opinion. Sometimes “watchful waiting” is the best clinical strategy. *These* waits need to be separated from those that cause harm.

2. How do doctors determine a patient's place in line?

Serving people according to their level of need requires assessing the *severity* and *urgency* of each patient's condition.

Severity refers to the degree of suffering, the limitations imposed on an individual and the risk of premature death. There are standardized pain measurement tools, but it is often difficult to compare degrees of suffering across patients because assessments of pain, disability and risk are subjective, thus open to variation.

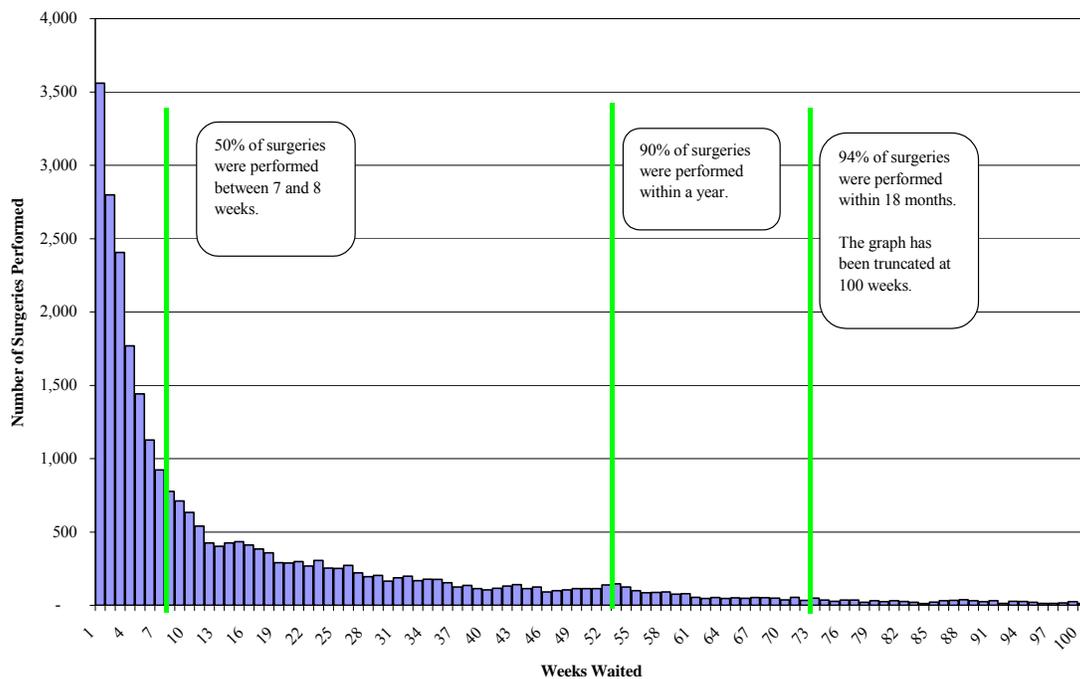
Urgency refers to the extent to which immediate clinical attention is required. Urgency rating generally requires a clinical judgement because it is tied to an understanding of the natural history of the untreated condition. Patients requiring immediate attention are treated as emergencies.

3. What do we know about waiting times and access?

Though taken by the public to reflect the system's performance, waiting lists can be very misleading. The distribution of waiting times for people on wait lists illustrates the problem. As Figure 1 illustrates, most wait times show a “peak” in service delivery with only one-week waits. This is followed by a long “tail” of extensive waits. Most people get timely care. Most public attention goes to those who wait – or appear to wait – too long.

Figure 1.

Most waits for care are within clinical targets: The Saskatchewan Surgical Care Network (SSCN) collects and reports information on wait times for surgical services. Some people clearly wait too long for care – either because the system has failed to attend to them in a timely manner or because they should not be on a waiting list in the first place. (In the latter case, we can hardly say they wait too long.) However, half of all Saskatchewan surgeries performed between January and June of 2004 were done within eight weeks of the surgeon’s booking. Ninety percent of all surgeries were performed within one year of booking. (Glynn 2004). For updated information see the SSCN website at: www.sasksurgery.ca.



Physicians’ criteria for placing patients on waiting lists vary widely; so do their practices for monitoring, reordering the list according to patients’ needs, and removing people who no longer belong. For some physicians and medical specialties, waiting lists identify those patients they wish to monitor closely. These patients are on a waiting list for clinical reasons. So long as their status is regularly assessed, and they are routinely informed and engaged in these assessments, their wait poses no therapeutic risk. They do not require an intervention immediately and, indeed, may not need – or choose – to have one at all.

Some people are on waiting lists for personal reasons; they may wish to choose a convenient time to receive care or to wait for care from a particular provider. At least one

fifth of people on wait lists postpone or cancel their own procedures. Some people on lists may have moved; others may have died.

Studies in the United Kingdom and New Zealand found significant over-counting of patients on lists, commonly at 30% and sometimes as high as 70%. Unless the system can identify and remove people who no longer need care, they are likely to remain on the waiting list – and create the appearance of increasingly long wait times.

So, it is not waiting lists that should be of concern but waiting that nobody wants – waits that are uncertain, waits that are unfair, and waits that are too long. A well-functioning access management system must focus on reducing the risk of fatal and non-fatal irreversible events and limiting the burden of symptoms for those waiting for care.

3.1 Patients compete for hospital resources.

In large hospitals, the majority of hospital services – beds, operating rooms, nursing care – are consumed by patients admitted on an emergency basis. This leaves little room for those who need beds for scheduled procedures.

The interaction between scheduled and emergency surgeries is complex. Patients who have been on a waiting list for scheduled surgery sometimes get worse and come in through the emergency department. And conversely, it is common for patients assessed in emergency to be given a less urgent classification and be discharged, but placed into a scheduled or semi-urgent waiting pattern for a needed procedure. For example, an unstable wrist fracture in an adult can safely be put in a cast for a few days before surgery is done. A man presenting at the emergency department with a gall bladder attack may be diagnosed as definitely requiring surgery. But he may be placed on a waiting list with others who need the same surgery.

When the collision between non-urgent and urgent patients becomes too frequent, physicians can be faced with a decision about who comes first, the patient in emergency or the patient who has been waiting and may already have been cancelled several times. (Vertesi 2004)

Whatever the time-sensitivity of a contemplated procedure, there must be evidence of a benefit that will not otherwise occur. Since all procedures carry a risk, their potential benefits and harms must be considered for each patient. Assessments of net benefit are always made prospectively – that is, before the actual intervention or treatment takes place. Regular post-intervention assessments of benefits provide important evidence of the value of the intervention and of appropriateness of the threshold – the correct level of need – for intervening. If thresholds are not set at the right level, people may receive unnecessary or, worse still, harmful care.

3.2 Variations in rates of non-urgent surgery and a lack of outcome measures raise questions about appropriateness of care.

A study that explored indications for and outcomes of non-urgent surgery found a wide range in levels of symptoms and disability at which surgery for some non-urgent

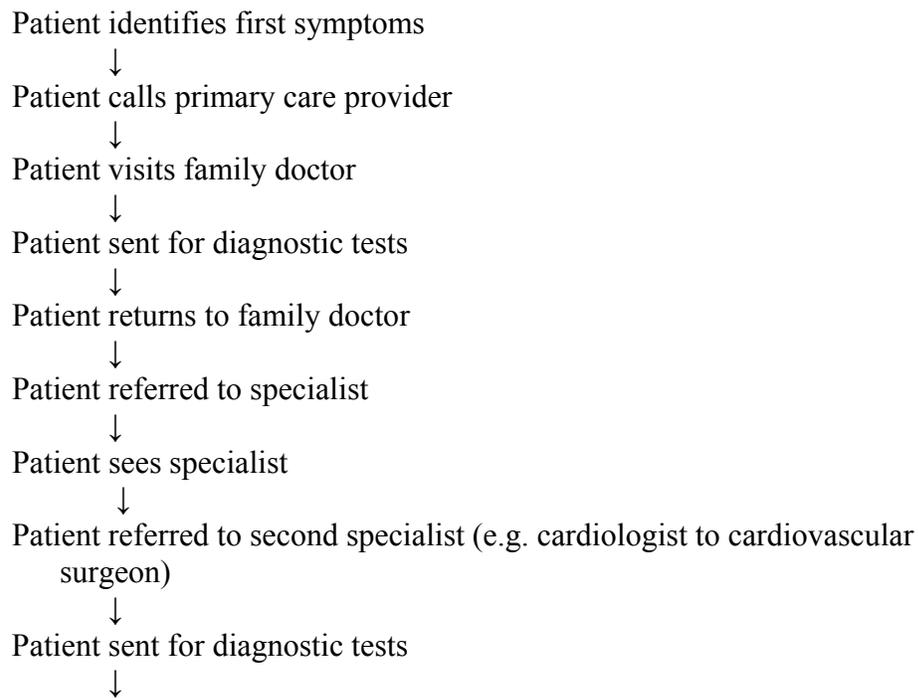
procedures was recommended. Study participants included 138 surgeons and 5,313 patients booked for six high-volume non-urgent surgical procedures at five acute care hospitals in the Vancouver health region. Disease-specific outcome measures showed benefits from surgery in all procedure groups. However, the measures also identified cases where patients' conditions had worsened after surgery. These ranged from 2% of patients who had received total hip replacement to 26% -- more than one quarter -- of patients who had had cataract replacement. A significant percentage of patients scheduled for cataract surgery scored high on visual acuity tests *before* their surgery. This suggested that the threshold indications for cataract surgery were very low. (Wright et al. 2002)

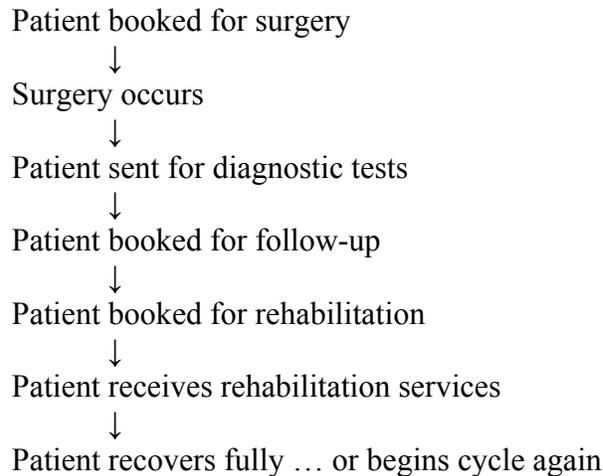
3.3 The patient journey can be long and winding.

Most Canadians only think about the health care system when they – or someone they know or love -- experience symptoms of illness, injury or disease. Some of these people will not use the health care system. Their illness will self-resolve or they will manage the symptoms themselves, at home. But as described in Figure 2, for those who do need care, the journey to an improved state of health can be long and winding. Moreover, these steps can be longer and more difficult for patients living in remote areas. It is fair to ask how this patient journey can be simplified. Why do these waits for care arise and what can be done to reduce or eliminate them?

Figure 2. (An illustrated version of this diagram appears on p. 28 of *Health Care Renewal in Canada: Accelerating Change*.)

The patient journey: from symptoms to surgery





3.4 Waiting occurs for many reasons.

Too many steps in the journey:

There are many steps in the patient journey with waits at every point. Simplifying the journey relies on the synchronization of these many independent components, operating at multiple levels in the system.

Multiple accountabilities for access:

If access at each step is managed independently, it is not clear who should be held accountable for stalls along the way. The integration of many components of the health care system under the administration of regional health authorities has helped to improve patient care and flow management but certain key components, such as family physicians and specialists, operate independently under separate accountability frameworks.

Failure to attend to “the tail”:

While some people wait for reasons of their own or their doctor’s choosing, others escape the attention of the system and simply wait too long. A well-functioning system must pay attention to the distribution of wait times, recognize both the physical and psychological impacts of excessive waits, and attend to those who wait too long.

Failure in foresight:

Scheduled surgeries are often displaced by emergency cases, leading to longer waits. While some emergency demands are unforeseeable, such as the SARS epidemic that crippled Ontario hospitals in 2003, other demands, such as seasonal peaks in accident rates or flu cases, are predictable. Inability to cope with the unforeseeable is forgivable. Inability to manage routine variation is a failure in planning and leadership.

Rapidly growing demand:

Technological advances have greatly increased both the number of interventions and their scope of application. Patients once considered too fragile for gall bladder surgery

(cholecystectomy) are now able to benefit from a less invasive procedure (laparoscopic cholecystectomy) which accomplishes the same end with less risk. The growth in numbers of surgeries performed each year is matched or outpaced by the growth in numbers of people who could benefit from them.

Threshold creep:

While new, less invasive surgical technologies can lead to lowering of the threshold for intervention, excess capacity can also have this effect – and do no good for patients. If the threshold for intervention is set too low, the risks may outweigh the benefits of care. To ensure the wisest use of valuable health care resources, outcomes need to be measured at various stages, over both the short and long term. And this information needs to be fed back to clinicians and administrators to ensure the intervention threshold is right.

4. What is currently happening on timely access?

Efforts to improve the management of waiting lists and wait times have been initiated at local, regional, provincial, and multi-jurisdictional levels across Canada. Many of these efforts involve a wide range of groups concerned with improving access, from patients and clinicians, to ministries of health, hospitals, regional health authorities, and health researchers.

Canadians are not alone in their preoccupation with waiting lists and waiting times. Many health care systems resembling ours face public concerns related to access to care. A study conducted by the Organization for Economic Cooperation and Development (OECD) examined the policies to address excessive waits for scheduled surgeries across twelve countries. They found a wide range of policies aimed at increasing capacity and managing demands. (Hurst and Siciliani 2003)

More on what's been done: Several useful summaries of activities underway in Canada and elsewhere around the world have been published. These include:

Canadian Policy Research Networks' summary of conference proceedings, *The Taming of the Queue: Wait Time Measurement, Monitoring and Management*. Available on the CPRN website at: <http://www.cprn.org/en/doc.cfm?doc=825>

Canadian Medical Association's discussion paper, *The Taming of the Queue: Toward a Cure for Health Care Wait Times*. Available on the CMA website at: http://www.cma.ca/multimedia/staticcontent/CMA/Content/Images/Inside_cma/MediaReleases/pdf/Taming-Queue.pdf

Organization of Economic Cooperation and Development's international comparative survey conducted by Jeremy Hurst and Luigi Siciliani, *Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries*. Available on the OECD website at: <http://www.oecd.org/dataoecd/31/10/17256025.pdf>

5. What are the immediate issues and challenges?

5.1 Lessons learned

A number of important lessons may be drawn from these experiences. The good news is there are high impact, low cost steps that can be taken to improve timely access to care. Key elements of a successful program to measure, monitor and manage wait times include:

- *Ensuring comprehensiveness* – **A comprehensive approach to measurement, monitoring and management of waiting times and access needs is essential to protecting equity between areas of competing demand for limited health care resources.** Competition not only exists between different surgical specialties, but also between community and institutional-based services. Care must be taken to ensure that attention and resources are not solely dedicated to those areas being tracked, such as to surgical interventions as opposed to whole patient management.
- *Making information publicly available* – **Making reliable and comparable information on wait times accessible to providers and the public promotes a better understanding of the issues and where the problems lie.** Centralizing the management of wait time data collection increases the likelihood that it is accurate and comparable. Standardizing terms and measures – defining when waiting starts and ends and achieving agreement on terms such as thresholds, indications and priorities – is essential in order to compare and measure performance. Regular reviews of waiting lists should be conducted to ensure that priority assessments are still valid and that people are not either waiting excessively long or no longer need to be on the list.
- *Evaluating outcomes* – **Outcomes of health care interventions need to be evaluated to ensure that thresholds are set appropriately and that health care resources are used as cost-effectively as possible.** Determining when an intervention is warranted should involve much more science and much less subjective opinion.
- *Engaging all key players in simplifying the patient journey* – **Addressing the many potential blockages in the patient journey requires the active participation of patients, clinicians, managers and administrators at all levels.** Engaging all key players in a review of the steps in the treatment journey and seeking their advice and cooperation on simplifying or speeding up processes can lead to dramatic improvements in wait times. Better predictive models coupled with active capacity management strategies could reduce the levels of uncertainty experienced by patients and providers as well as ensuring that both the emergency and scheduled streams are fairly treated.
- *Aligning the incentives* – **Making timely access matter to all involved is key to improving productivity and ensuring continuous quality improvement.** Creating appropriate reward systems to ensure all providers, including clinicians,

managers and administrators, are recognized for both the quantity and quality of health care interventions is essential.

- *Enhancing capacity where needed* – **New resources must be viewed as investments in concerted change or they will quickly be absorbed by an unorganized care access system.** In addition, attention needs to be given to ensuring that there are no weak links in the supply chain – that professional, technical and support staff, required supplies, and physical facility are all aligned at the right time and place.
- *Defining the need* – Methods such as clinically-validated community-based surveys should be undertaken to determine the level of need of the population, to understand implications for capacity, and to identify disparities in access to appropriate care. (Hawker et al 2001)

The problems with respect to wait times and access will not be solved overnight. Incentives that make good organization and efficiency matter are imperative. Getting to solutions will require the ongoing commitment of all key players to a common vision and action plan. Investment is needed but only if it buys the required changes. Fortunately, there is more receptivity to change and the will to accomplish it than has been the case in the past.

5.2 Next steps

The Health Council of Canada can play a role in supporting progress on wait times and access. While not involved in creating or implementing improvements in timely access, the Health Council can continue to analyse and comment on progress. Among other things, the Council will:

- Continue to explain to the public how and why waits occur
- Inform the media so that they have a more balanced and sophisticated understanding of a very complex system
- Highlight best practices and recommend to the jurisdictions those with a solid evidence base
- Monitor the impact, both intended and unintended, of different strategies, including focussing on select areas for reducing wait times and introducing incentives to change behaviours and practices
- Undertake a closer analysis of selected key problem areas, such as emergency departments, MRI, and community mental health services
- Promote research and evaluation so that the system benefits from an ongoing intelligence network

We look forward to the work ahead.

References

- Badley EM (2004). *Arthritis related conditions in Ontario*. Institute for Clinical Evaluative Sciences.
http://www.ices.on.ca/webpage.cfm?site_id=1&org_id=31&morg_id=0&gsec_id=0&item_id=2233
- Glynn PAR, Donnelly LM, Calder DA, Brown JC (2003). The Saskatchewan Surgical Care Network – toward timely and appropriate care. *Hospital Quarterly* 7(1).
<http://www.longwoods.com/hq/index.html>
- Hadorn DC and the Steering Committee of the Western Canada Waiting List Project (2003). Setting priorities for waiting lists: defining our terms. *CMAJ* 163(7):31-35.
<http://www.cmaj.ca/>
- Hawker GA, Wright JG, Coyte PC et al (2001). Determining the need for hip and knee arthroplasty. *Medical Care* 39(3):206-216.
- Hurst J and Siciliani L (2003). *Tackling excessive waiting times for elective surgery: a comparison of policies in twelve OECD countries*. OECD Health Working Papers 6.
<http://www.oecd.org/dataoecd/24/32/5162353.pdf>
- Lewis S, Barer ML, Sanmartin C, Sheps S, Shortt SED, McDonald PW (2000). Ending waiting-list mismanagement: principles and practice. *CMAJ*; 162(9):1297-1300.
- Sanmartin C, Shortt SED, Barer ML, Sheps S, Lewis S, McDonald PW (2000). Waiting for medical services in Canada: lots of heat, but little light. *CMAJ* 162(9):1305-1310.
- Sanmartin C (2001). *Establishing Acceptable Waiting Times for Medical Services: A Review of the evidence and proposed methods*. Western Canada Waiting List Project.
www.wcwl.org
- Sanmartin C (2001). *Toward standard definitions of waiting times for health care services*. Western Canada Waiting List Project. www.wcwl.org
- Saulnier M, Shortt SED, Gruenewoldt E (2004). *The taming of the queue: toward a cure for health care wait times*. Canadian Medical Association Discussion Paper.
http://www.cma.ca/multimedia/staticcontent/CMA/Content/Images/Inside_cma/MediaReleases/pdf/Taming-Queue.pdf
- Statistics Canada (2003). *2003 health services access survey*. June 30 2004.
www.statscan.ca
- Wright C, Chambers GK, Robens-Paradise Y (2002). Evaluation of indications and outcomes in elective surgery. *CMAJ* 167(5):461-466.
- Vertesi L (2004). Does the Canadian Emergency Department Triage and Acuity Scale identify non-urgent patients who can be triaged away from the emergency department? *Canadian Journal of Emergency Medicine* 6(5):337-342.