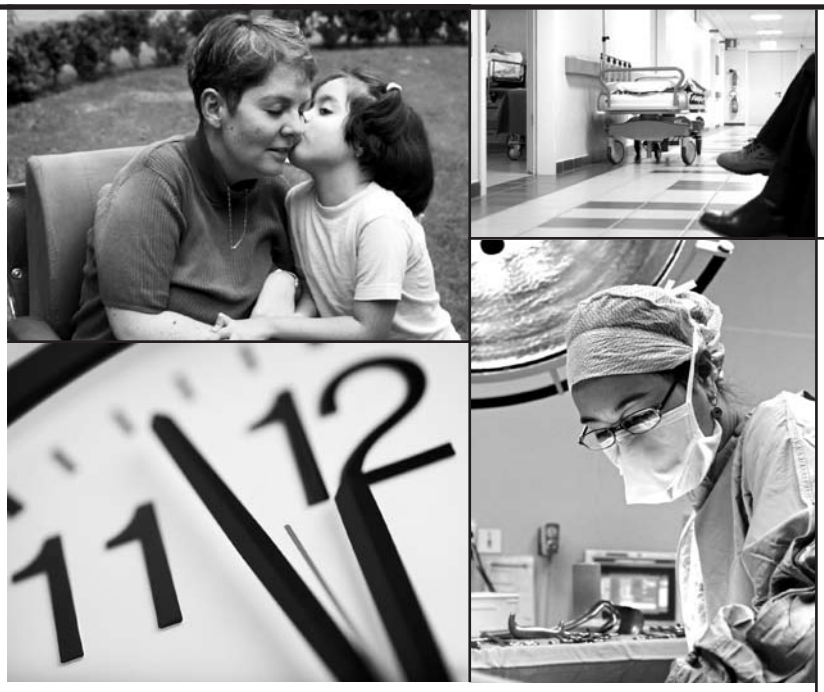
WHY WAIT?

PUBLIC SOLUTIONS TO CURE SURGICAL WAITLISTS



By Alicia Priest,
Michael Rachlis
and Marcy Cohen

MAY 2007

BC Health Coalition

CCPA
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for POLICY ALTERNATIVES
BC Office

A SUBMISSION TO THE BC GOVERNMENT'S CONVERSATION ON HEALTH

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By Alicia Priest, Michael Rachlis and Marcy Cohen

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Co-published by the Canadian Centre for Policy Alternatives and the BC Health Coalition

ACKNOWLEDGEMENTS

The authors would like to thank Shannon Daub, Colleen Fuller, Michael Klein, Seth Klein, Margaret McGregor, Bob McMurtry, Ben Parfitt, Patricia Wejr and Gavin Wilson for their helpful feedback on this report.

Thanks to the Hospital Employees' Union for their financial contribution to this work.

Any errors and the opinions presented in this paper are those of the authors, and do not necessarily reflect the views of the Canadian Centre for Policy Alternatives or the BC Health Coalition.

Copyedit and layout: Nadene Rehnby, www.handsonpublications.com

ISBN: 978-0-88627-532-7

Printed copies: $10. Download free from the CCPA website.

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Summary

Waiting for elective surgery is the hottest political issue facing Canadian health care today. In fact, it's no exaggeration to say that how waitlists are managed – or not – could seal the fate of Medicare.

The central point of this paper – and the good news – is that better management is happening right now in BC and elsewhere, and as a result waitlists for certain surgical procedures have decreased dramatically. Changes to public health care policies and practices by dedicated health professionals have cut months from wait times while reducing lengths of stay in hospital and increasing patient satisfaction.

Positive information of this nature deserves to be celebrated, especially in these times of health care gloom and doom. The public needs to know that these projects exist; that there are viable, economically achievable solutions, and that they hold great promise for improving Medicare.

- The Richmond Hip and Knee Reconstruction Project, for example, introduced system and surgical innovations that slashed median wait times by 75 per cent. By staggering operations between two dedicated surgical rooms focused on hip and knee reconstruction, standardizing practices, and investing in new equipment, the Richmond project has been able to capitalize on the efficiencies that come with specialization (just like the for-profit clinics), but without public dollars being siphoned off to private owners' profits.

  What's more, operating room efficiency increased by 25 per cent allowing team members to complete 136 per cent more cases. At the same time, average lengths of stay in hospital fell from five days to four for hips and four days to three for knees.

- At North Vancouver's Lion's Gate Hospital, the Joint Replacement Access Clinic – a one-stop, centralized booking service for pre-operative and post-operative appointments – cut times for patients waiting for their first surgical consult from over 11 months to just two to four weeks.

- At Vancouver's Mount Saint Joseph Hospital, operating room efficiencies and investments in technologies have allowed ophthalmologists to perform 50 per cent more cataract surgeries – taking 50 per cent more people off their waitlists – without any increase in operating room time.

The provincial government needs to embrace these successes and make them the rule, not the exception. However, so far, that has not happened. Instead, when Premier Gordon Campbell announced BC's Conversation on Health, he suggested that public involvement in health is no longer financially sustainable, implying that we should consider a larger role for private insurers and private providers. Yet choosing that path flies in the face of evidence showing that private, for-profit care costs society more, is less safe for patients and compromises the public system. There is further reason for concern due to the government's favourable response to Canadian Medical Association president-elect Brian Day's proposal for a competitive market in health care based on recent reforms in the United Kingdom. Based on evidence from Britain, such changes would undermine rather than sustain public health care and undo the very real gains made by the BC waitlist strategies profiled in this report.

The government needs to shift direction and, instead of promoting private solutions, become the champions of public waitlist reforms. Several public sector initiatives in other provinces point out specific actions BC can take to ensure that the innovations already underway in BC are scaled up to a provincial level. For example:

- The Alberta Hip and Knee Replacement Project, where simple, common-sense changes in processes of care cut joint replacement wait times from 19 months to 11 weeks;
- Saskatchewan's Surgical Care Network, a comprehensive, pro-active surgical database used by health authorities in cooperation with surgeons to shorten wait times for surgery; and
- Ontario's Wait Times Strategy, an ambitious, multi-pronged effort aimed at reducing wait times in five high-demand areas by increasing funding, boosting hospital accountability, investing in information technology and improving quality.

The big story that emerges out of all these projects is that better management of waitlists requires two major changes. The first calls on physicians to make the shift from working mainly on their own, to working in teams – with their own specialty group, with other physicians (especially in primary care), and with other health care workers. Doctors play a central role in health care delivery, and their support is critical. When physicians work in high-functioning teams, as in the examples cited in this paper, the system functions more efficiently and waiting lists shrink. For example, access to surgery improves when advanced practice nurses are able to work to their full scope of practice in capacities such as nurse anesthetists.

The second change involves transferring accountability for waitlist management from individual surgeons to health authorities working with groups of surgeons and other health professionals. This involves putting patients on a single, common waitlist rather than on a multitude of individual doctors' lists. However, this reform does not prevent patients from taking advantage of a long-established strength of the Canadian health system: the right to choose a surgeon.

In British Columbia, the Ministry of Health, health authorities and the BC Medical Association (BCMA) recently attempted to create such a common surgical waitlist: the BC Surgical Patient Registry. However, unlike their counterparts in Saskatchewan and Ontario, the government of BC chose to negotiate key terms of the registry with the BCMA. These conditions included how registry information could and could not be used. Instead of supporting physicians such as those featured in this paper who are actively engaged in real system change by, among other things, working in teams, the agreement appears to leave most waitlist management and coordination to individual physicians. It also appears to restrict the ability of health authorities to re-direct patients. Understandably, such a shift is a huge cultural change that some surgeons may resist. Given that probable opposition, the provincial government needs to take charge because, as this paper consistently shows, there are substantial benefits to patients and the system from team-based care.

This report concludes that the BC government must make a choice. It can significantly reduce surgical waitlists across the province by building on and scaling up the public sector initiatives already underway. Or it can throw up its hands, declare the system unsustainable, and replace our cherished public system with a private health care market. If it does the latter, waitlists in the public system will only grow longer and the prediction of unsustainability will become a self-fulfilling prophecy.

Recommendations to the Province

- Replicate and expand on the successes achieved in pilot projects in North Vancouver, Richmond, UBC and elsewhere by providing dedicated resources and oversight so that these initiatives become the rule rather than the exception.
- Shift accountability for ensuring smooth surgical flow and waitlist management from individual surgeons to a regional group of surgeons, and from individual hospitals to health authorities.

Introduction

No conversation about Canadian health care can avoid the topic of lengthy waitlists. Although close to 85 per cent of Canadians say they are "very satisfied" or "somewhat satisfied" with the overall way health care services are delivered,[1] too many are anxious, frustrated and angered by untimely waits to see a specialist, get diagnostic tests or undergo elective surgery. Most of us either know someone who has experienced a long wait or have endured one ourselves. Bottlenecks, roadblocks and delays can exist at almost every step of the journey to the operating room – and even after on the road to recovery. That's troubling because undue waiting can aggravate health problems and in some cases increase surgical risk and compromise full recovery. No wonder long waits are the hottest political issue facing Canadian health care today.

It is no exaggeration to say that how waitlists are managed – or not – could seal the fate of Medicare. Unacceptable wait times have been described as the Achilles heel of the Canadian health care system.[2] The metaphor, used to describe vulnerabilities so vital they can lead to a system's downfall, is fitting in the case of creeping privatization of health care at the expense of the public system (see *Why Not Go Private?* on page 12). As health care commissioner Roy Romanow reported to the federal government in 2002, "long waiting times are the main, and in many cases, the only reason some Canadians say they would be willing to pay for treatments outside of the public health care system."[3]

The first step toward fixing a problem is understanding why it exists. But while citizens are acutely aware of the existence of untimely waits for elective surgery in the public system, they know little about why they occur and even less about how to reduce them. Although much fuss is made about how the growth in aging populations increases demand for surgery, we rarely hear about how advances in surgical techniques drive demand. Thanks to widespread use of far less invasive procedures, an 80-year-old British Columbian today is twice as likely to have a knee replacement, cataract surgery or a coronary bypass than he or she would have 15 years ago. To a significant degree, the health care

system is asked to perform more surgeries simply because it is more capable than ever of relieving patients' pain and suffering and increasing their quality of life.[4] Of course, this is a good thing, but the effect of more people demanding more surgery is longer waits.

Another key contributor to waitlists must be thoroughly examined precisely because it is one that can be addressed. The surgical process – before, during and after an operation – is technically complex and multi-faceted. It includes preparation for surgery, hospital admission, anesthesia, surgical procedure and recovery, and involves a wide range of health professionals working in different areas of a hospital and a number of community settings. Traditionally, the system has relied on individual physicians and their office staff to manage and direct the many steps in the process. For example, it is up to surgeons and their office staff to make multiple appointments for patients at other specialists' offices, laboratories, radiology facilities and operating rooms. Because one appointment is often dependent on the outcome of another, and because no one is organizing patient traffic as a whole, congestion can occur at every stage.

One of the most frequently neglected steps in the surgical process is pre-surgical screening. Preparing patients for surgery – socially, psychologically and physically – and making sure they can cope at home after surgery reduces cancellations of operations. It also increases the likelihood that operations will be successful, recovery rapid and re-admission minimized. Yet, historically, no one is responsible for ensuring that all patients be fully screened and educated before surgery. This is largely due to the fact that most surgeons do not work as a team with nurses and other allied health professionals.

Another largely ignored part of the surgical process is practices that ensure the right patient has the right procedure. At times, that means not having the procedure at all. Although seldom discussed in the media, some medical interventions are inappropriate because they either are needless or actually do some patients harm. For example, a 2002 study by UBC medical researcher Dr. Charles Wright found that while 70 per cent of cataract surgery patients had improved vision after the procedure, for more than one quarter vision had worsened.[5] If patients who wouldn't benefit from surgery were screened out, waitlists would be shorter.

However, while there are reasons for concern, the good news is that some people in BC and elsewhere are doing things differently, and in so doing have dramatically reduced waitlists and wait times. If their reforms were embraced more widely, we could eliminate almost all untimely waiting. These changes involve fundamental organizational innovations, many of which are detailed below. Because physicians play the central role in health care delivery, many of these reforms are contingent on them. As these projects demonstrate, when physicians make the shift from working solo to working in teams – both within their own specialty groups and with other health care workers – the system functions smoother, quicker and waiting lists shrink. Team-based care enables nurses and other allied health professionals to assume broader clinical and coordinating roles while still working within their scope of practice. Under certain circumstances it can also help alleviate health care personnel shortages.

In December 2005 the Canadian Centre for Policy Alternatives released health policy analyst Dr. Michael Rachlis' research report *Public Solutions to Health Care Wait Lists*. That report was the impetus and foundation for this one.

Rachlis looks at how innovations in public delivery can significantly reduce wait times for health care.

Rachlis' central point is that delays for care are not usually due to a lack of resources but to poorly organized services. Shoddy or non-existent coordination, lack of flow and lack of consistency are some of the organizational problems contributing to health care bottlenecks. Inconsistencies or variations slow the flow and delay needed interventions. For example, every day valuable operating room time is taken up by the re-making and re-supplying of operating rooms according to the individual preferences of surgeons, even those doing identical procedures. Variation on any point along the continuum of care slows the system down. Most variation, however, arises from inefficiencies in the system and not from unpredictable elements such as changes in patients' condition.

Aiming to reduce variation and dramatically cut wait times, Rachlis offers a key innovation – the application of queuing theory. Queue-management theory is a branch of mathematics that has practical use in health care. Anyone who has ever lined up at a bank knows that single lines that feed into multiple tellers have better flow and are fairer than multiple line-ups feeding into multiple tellers. Yet generally in health care, surgeons maintain their patients on their own independent lists with no-one overseeing all lists. Most patients would welcome entering a pooled list so they could see the first specialist available, especially if that would cut months off their wait. If patients choose to stay with the same surgeon they can, although they may wait longer than others.

The good news is that some people in BC and elsewhere are doing things differently, and in so doing have dramatically reduced waitlists and wait times. If their reforms were embraced more widely, we could eliminate almost all untimely waiting.

A common waiting list is just one of several queue-management techniques applicable to health care. Another is stand-alone, specialized, short-stay clinics. Geared for low-risk elective surgery, stand-alone clinics allow for better flow, increased efficiency and ultimately shorter waits. Rachlis describes the workings of well-established public clinics in Manitoba and Ontario. These clinics achieve the efficiency benefits of specialization and innovation often ascribed exclusively to the private sector, while maintaining the public sector long-standing advantage of low overall administrative costs and broader societal benefits (see *Why Not Go Private?* on page 12).

Another form of queue management is the one-stop, multidisciplinary pre-surgery centre. Instead of forcing patients to ping-pong around town over a number of weeks in an effort to obtain various diagnostic tests or see various specialists, it makes more sense to consolidate as many services as possible under one roof.

Other helpful queuing management strategies Rachlis recommends are updated electronic information systems, standardized surgical procedures and a uniform way of allocating operating room time.

Whatever form public sector changes take, the bottom line, Rachlis says, is that they be driven by patient needs and not the needs of organizations or individual practitioners. Although technological advances have revolutionized the science of medicine, health care delivery has not kept up. Nonetheless, Rachlis concludes that public health care can deliver consistency, quality and timeliness, but only if these innovations are implemented on a larger scale.

Another recent report informs this paper. In June, 2006, the federal government released the report of the National Wait Time advisor, Dr. Brian Postl. Postl, who is also the chief executive officer of the

Winnipeg Regional Health Authority, noted that waiting times are not as bad as popularly portrayed, but are bad enough. He believes the public system, if properly funded, can reduce them. Echoing Rachlis, he points out that long wait times do not exist in isolation but are a symptom of archaic, deeply entrenched dysfunctions within the system. Drastically reducing and in some cases ending unreasonable wait times requires transforming the system to put patients at the centre of the action. While that task may sound overwhelming, Postl asserts that it isn't. His proof lies in the fact that the revolution has already begun.

"Examples from across the country and around the world demonstrate that it is possible…" Postl writes. "Canadians could potentially have same day access to primary health care, one or two weeks access for appointments with medical specialists, and almost no waiting for tests and surgeries."[6]

Postl urges all provinces and territories to adopt the following wait time strategies:

- A single common waiting list, rather than a multitude of lists managed by individual doctors or facilities;
- A wait-time champion to prod politicians and inspire care providers to address wait times;
- Queuing strategies to improve current organizational processes;
- A public-awareness campaign that helps people understand that some waiting for some procedures is not unreasonable;
- Team-based care that enables providers such as nurses to assume broader clinical tasks while working within their scope of practice;
- Practices that ensure the right patient has the right procedure; and
- Pre-surgical programs that prepare patients – physically and mentally – for surgery.

This paper focuses on six examples of BC innovations in managing surgical care within the public system that have successfully reduced waitlists or are designed to do so. As well, it looks at three innovations elsewhere in Canada: in Alberta, Saskatchewan and Ontario. Because very little of this information has been discussed in health care system literature, this report draws heavily on personal interviews with key players.

The range and extent of these projects are astounding, as is the excitement, commitment and dedication of their clinical and administrative leaders. Their results speak for themselves. The people involved are public health care champions. For the benefit of all Canadians, they deserve to be acknowledged, encouraged and supported in their work.

The following sections present BC queue-management projects addressing waitlists within the public system, divided into three categories:

- System redesign;
- Modernized information systems; and
- Improved waitlist registries.

Why Not Go Private?

Is more private care the answer to wait time woes? Some people, spurred by media stories of patients suffering from long waits for care in the public system, would say yes. Private facility owners assert they have the resources, the incentive and the know-how to meet patient needs far more efficiently and effectively than the public system – so why not let them? Proponents of this option envision a system of private providers who cater to people who can pay, and a public system that caters to people who can't. In fact, they say, if you have a public system with a parallel private system, the public system will actually function better. By acting like a valve on a pressure cooker, private providers siphon off patients that would otherwise overcrowd and overheat the public system. Furthermore, proponents say, the *only* way to solve the public waitlist problem is to introduce a mixed system with parallel public and private delivery.

Let's look at those claims. The pros and cons of a parallel private delivery system have been thoroughly studied by researchers around the world. Indeed, an essay by the Canadian Health Services Research Foundation refers to a peer-reviewed "mountain of evidence" against parallel public and private health care systems.[7]

This evidence tells us four things:

1. Public sector wait times are longer when there is parallel for-profit health care delivery

International studies show that countries with parallel public and private health care systems have longer, not shorter, public-sector waiting times than other nations.[8]

Canadian studies point to similar results. A 1998 study from the University of Manitoba found that cataract patients whose surgeons worked in both the public and private sectors waited 23 weeks for surgery, more than twice as long as patients whose doctors only worked in the public hospital system.

The problem stems from the fact that there is a finite pool of health professionals – both doctors and nurses. Private hospitals and clinics draw scarce human resources out of the public system, lengthening wait times for patients who want to access public services. As the Manitoba cataract example suggests, waitlists are longest for patients of doctors who work in both the public and private systems.[9] One reason is that doctors who work in both systems have an incentive to keep public waits long – that way they have a steady pool of patients willing to pay for private service.

2. Cream-skimming of easy-to-treat patients is common where there is parallel for-profit delivery

Cream skimming refers to the fact that for-profit clinics have a material interest in serving patients for whom procedures are less complex, outcomes more predictable and costs lower. It allows for-profit clinics to minimize their risk and maximize their profit. It also results in an increase in the average level of severity among patients who remain in the public system, and in the costs associated with their treatment. Consequently, the average cost of treating patients in public institutions rises. If payments

to the public system do not increase to reflect these higher costs, the public system becomes less sustainable. Evidence suggests that when public authorities are confronted with deteriorating health among patients waiting for care, they will divert patients to private clinics to relieve their suffering even when this may threaten the sustainability of the public system in the long run.[10]

3. Care delivered in for-profit facilities is less safe

A key reason for poorer quality of care and health outcomes in for-profit facilities is the lower number of skilled personnel employed. In 2002, a study in the Journal of the American Medical Association reported that patients at for-profit dialysis clinics had an 8 per cent higher death rate than those attending non-profit clinics,[11] and a lower chance of being referred for a kidney transplant.[12] But it wasn't the only study to find such sobering outcomes. The same group also published an overview of all individual studies comparing mortality rates for 26,000 for-profit and non-profit hospitals serving 38 million patients. They found that adults had a 2 per cent higher death rate in for-profit hospitals, while newborns had a 10 per cent higher rate.[13] They concluded that concerns that the profit motive may adversely affect patient outcomes in for-profit hospitals were justified. The investigators estimated that if all Canadian hospitals were converted to for-profits, there would be an additional 2,200 deaths a year.

The recently established for-profit surgery clinics in the UK, Independent Sector Treatment Centres (ISTCs), have had similar problems with less safe care. In a House of Commons Health Committee report on ISTCs both the Royal College of Surgeons and the British Medical Association voiced concerns about the quality of care in the ISTCs.[14] And in a survey by the British Medical Association of clinical directors in the National Health Service (NHS) working in orthopaedics, ophthalmology and anesthetics, two thirds reported patients had returned to NHS for after-care with higher readmission rates from the for-profit ISTCs than from NHS-run clinics.[15]

4. For-profit care costs more

The international experience with private surgical facilities is that they tend to charge higher prices for the same surgery in a publicly-funded hospital. Much higher.

The British Medical Journal reported in 2004, for example, that the National Health Service was charged 47 per cent more for hip replacements performed in private surgical clinics than for the same procedures provided in public hospitals. In 2002/03, a coronary bypass operation cost an extra 91 per cent in a private clinic in England compared to a non-profit hospital.[16]

The experience in Canada is similar. For example, hip replacement surgery in a non-profit hospital in Alberta last year cost a reported $10,000.[17] Hip replacement surgery in a for-profit clinic, according to Timely Medical Alternatives (which facilitates access to the clinics), can cost up to $21,780.[18] In Canada's public hospital system, knee replacement surgery, according to the Canadian Institute for Health Information, averages $8,002[19] compared to between $14,000 and $18,000 in a private surgical facility.[20]

The evidence is clear – private for-profit care is less fair, more costly and poses a greater risk to patients than not-for-profit care.

System Redesign Projects

Richmond Hip and Knee Reconstruction Project

More than two years ago, the Richmond Hip and Knee Reconstruction Project set out to decrease the number of people waiting for hip and knee replacement surgery in the Lower Mainland while learning from the best practices in the world. The pilot project was a collaboration within the public sector, including the Provincial Surgical Services Project (see page 23), the Vancouver Coastal Health Arthroplasty Team, the Provincial Arthroplasty Collaborative, and Vancouver Coastal Health's Centre for Clinical Epidemiology and Evaluation.

In addition to decreasing wait times, other project goals included decreasing lengths of stay in hospital and improving patient outcomes, all in a community hospital setting. The project's success is unequivocal, and the program is now an entrenched part of Richmond Hospital. The project's accomplishments include:

- Median wait times down by 75 per cent, from 20 months to five months;
- Overall numbers on waitlists shrunk by 27 per cent;
- Number of people waiting more than 26 weeks decreased by 63 per cent;
- Cases completed increased by 136 per cent;
- Average lengths of stay in hospital down by 25 per cent, from five days to four for hips and four days to three for knees (when the project began, average lengths of stay in BC were eight days for hip replacements and six for knee replacements); and
- Operating room efficiency increased by 25 per cent.

So how did they do it? Dedicated funding of $1.3 million meant the project had a full-time manager, equipment, research and evaluation tools, a newly-renovated operating room and new operating suite equipment. Funding came from the provincial government, the Vancouver Coastal Health Authority

and the Richmond Hospital Foundation. But as numerous health care analysts know, money alone can't buy success. In this case, however, money combined with numerous surgical efficiencies did.

Operation start times were staggered and scheduled between two rooms, so surgeons could "swing" between rooms as their patients were ready. This allowed operating teams to complete eight joint replacements or reconstructions per day instead of six. Surgical procedures and clinical practices were standardized, eliminating previous idiosyncratic variations. For example, previously the group of surgeons used nine types of prosthetic devices between them, depending on each surgeon's preferences. During the project all surgeons used the same one, making work smoother for nurses and others assisting procedures. The move also resulted in significant savings for the hospital as it could negotiate better deals on bulk purchases.

Project co-leader Cindy Roberts says the initiative's core strength was that it included everyone, from cleaners to community care workers. Her co-leader was Richmond orthopaedic surgeon Ken Hughes.

"We educated all involved, including the surgeons as to how their work affects everyone else down the line," Roberts says.

Like in many private clinics, the two Richmond project operating rooms are able to capitalize on the efficiencies that come with specialization. However, unlike with private clinics, public dollars are not siphoned off to private owners' profits.

UBC Centre for Surgical Innovation

Another project achievement coming out of the Richmond Hip and Knee Reconstruction Project was the development of The Arthroplasty Plan (TAP), a model available as a toolkit allowing other sites and health authorities to share what the Richmond team learned. The University of British Columbia Hospital took up the challenge in April 2006, and opened its Centre for Surgical Innovation (CSI), a $25 million, one-year provincial pilot project dedicated to fast tracking patients for hip and knee replacement surgery. CSI is specifically geared to serve low-risk patients who have been on a waiting list for more than 26 weeks. The project has two dedicated operating rooms and 38 inpatient beds, and aims to perform 1,600 surgeries a year. As of late January, CSI had carried out more than 1,100 procedures.

CSI differs from the Richmond program in that it is a province-wide service, involving about 25 orthopaedic surgeons, and their patients, from Vancouver Island, Interior Health, Northern Health, Fraser Health and Vancouver Coastal Health regions. Based on the TAP model, the centre applies similar practices such as "swing" operating rooms, standard clinical pathways and patient outcome measures. Some surgeons have picked up the swing concept and introduced it to their home communities. Even though out-of-town patients are not compensated for their travel to Vancouver, they are eager to come, says CSI project leader Laurie Leith.

"Some have been on a surgical wait list for one to two years," Leith says. "Ideally, they would like it done in their home community. However, they're so happy they're willing to do whatever it takes to have it done."

Although it's too early for a final evaluation, CSI's achievements are obvious. Average stays have fallen below their target of four days for hips (3.25 days) and are on target at three days for knee procedures, demonstrating the important connection for success between in-hospital patient care and pre- and post-hospital care. All patients receive pre-operative teaching – some in their home communities – to ensure they are well-prepared for surgery. Post-operatively, every patient receives a follow-up call after discharge to determine how satisfied they are with the program. So far patients are rating the program an average of 4.7 out of 5.

Leith says there is no doubt the program has made a significant dent in wait times for hip and knee replacement surgery throughout BC and she is optimistic it will receive on-going, sustainable funding.

North Shore Joint Replacement Access Clinic

The North Shore Joint Replacement Access Clinic (JRAC) exemplifies a slightly different but equally effective way to decrease wait times for hip and knee replacement surgery. By focusing on the front end – the preparatory work before patients undergo surgery – the JRAC has dramatically reduced wait times both before a first surgical consult and before the surgery.

Twelve other BC sites have visited the North Shore clinic and are interested in establishing similar practices. Says project co-founder and nurse Chantel Canessa, "You have to look at what you're doing, think outside the box, and listen to the patients – they have some great ideas."

JRAC is a one-stop, centralized booking service for pre- and post-operative appointments and procedures. It opened as a pilot project in May 2005 and is now a permanent facility at Lions Gate Hospital. Lions Gate orthopaedic surgeon Paul Sabiston was a driving force behind the changes, along with clinic co-founder and orthopaedic nurse Chantel Canessa. Canessa says the idea originated from a survey asking former hip and knee patients about their greatest concerns. After lengthy wait times, patients complained of the last-minute anxiety they experienced when, after waiting for up to two years, they suddenly were given a surgery date and had two or three weeks to undergo all of their pre-operative appointments, including x-rays, lab work and visits with anesthetists. Family doctors were also frustrated that their patients had to wait so long before their first visit to a specialist.

Solving some of those concerns did not require a huge infusion of provincial health care dollars. Instead it involved applying a few simple, common sense ideas that accelerated patient flow. As Canessa says, "We didn't have any money to open the clinic, so we had to be creative." The clinic took over space formerly used as an overflow clinic and staff donated tables and used furniture.

Waitlists were immediately shortened by pooling patients on a common list and having patients agree to accept either the first surgeon available or one of their choice. Then wait times were tackled by creating a central, hospital-based clinic dedicated to prospective joint replacement patients. This allowed clinic staff to coordinate and streamline dates for tests such as X-rays and laboratory tests, and physiotherapy and pharmacy consults. Anesthetists now see high-risk patients two months

before surgery instead of two days before so they can identify and address problems well in advance. Significantly, no joint replacement surgeries have been cancelled since that practice began, says Canessa. The clinic also screens and prioritizes patients before surgery and refers appropriate patients to community resources such as exercise programs and nutritional counseling.

"It was just little things," Canessa says. "We moved the workload ahead."

The project received an additional $5 million from the provincial government, which allowed a formally idle operating room at Lion's Gate Hospital to be re-opened, dramatically increasing the number of operations performed.

To date, JRAC's accomplishments include:

- Reduced wait times for first surgical consult from almost a year to just two to four weeks;
- Reduced wait times for surgery for most patients from up to two years to six months or less;
- A 140 per cent increase in the number of hip and knee surgeries between 2003 and 2005; and
- A post-operative patient survey yielding a satisfaction rating of 97 per cent.

Twelve other BC sites have visited the clinic and are interested in establishing similar practices. Says Canessa, "You have to look at what you're doing, think outside the box, and listen to the patients – they have some great ideas."

Mount Saint Joseph Hospital Cataract and Corneal Transplant Unit

Mount Saint Joseph Hospital is a 140-bed, acute-care, community-based hospital in East Vancouver best known for its multicultural approach to care delivery, especially for the city's large Chinese community. Over the past three years it has become renowned for something else – a cataract and corneal transplant program that outperforms every hospital in the province. By completing more than 6,300 procedures a year, the program has cut wait times in half (from six to eight months to three to four months), with many patients having the procedure within 10 weeks.

Head ophthalmologist Pierre Faber explains that because there is little variation with cataract surgery, it lends itself well to production-line efficiencies without loss of quality. A decision to invest in the best technology, and in more equipment so that surgeons don't wait for tools to be sterilized, allowed them to immediately get up to speed. Faber boosted the number of procedures he performs from 12 a day to 17.

"Basically, we've been able to eliminate a lot of the downtime," he says. "So by 1:30 in the afternoon the instruments I used at eight in the morning have been through the system and are ready for their second go. Without giving me any more actual operating room time, they've given me 50 per cent

more surgery. So therefore I'm going to take 50 per cent more people off my waitlist. And that's true of everyone, not just me."

Other moves that increased efficiency were bulk buying of supplies and moving the procedure out of high-intensity operating rooms to a specifically designed procedure room. All surgeries are done as day-surgeries and without the use of a general anesthetic.

Although the group of eight ophthalmologists does not have a common waiting list, they monitor their lists together. Operating time is allocated according to the amount of time each patient waits, not by how many are on a particular surgeon's list.

"The idea," Faber says, "is that no matter who you go to in this group of eight, you will probably wait the same amount of time."

As for pre-surgical screening, the group looked to research literature that supported their decision to eliminate routine blood tests and EKGs for low-risk cataract patients. Ironically, a shortage of anesthetists has resulted in another saving to the system. The hospital now uses OR nurses trained to administer and monitor the low levels of sedation used in cataract surgery.

On the whole, Faber says patients and surgeons are thrilled with the program's smooth and successful operation. In fact, seeing what sufficient funding and the application of efficiencies can do has given him new faith in the public system.

But Faber is frustrated by the current financial set-up, which makes nurses more expensive for hospitals than doctors. That's because nurses are paid out of a hospital's budget while anesthetists are paid through the Medical Service Plan and are therefore a freebie for the hospital. Yet from a business perspective, it doesn't make sense to hire a $250,000 anesthetist when you could hire two or three nurses for the same money.

"It all comes out of the same Ministry of Health pot," Faber says. "It's just coming out of a different pocket."

On the whole, Faber says patients and surgeons are thrilled with the program's smooth and successful operation. In fact, seeing what sufficient funding and the application of efficiencies can do has given him new faith in the public system.

"I've worked in the [for-profit] Cambie [Surgery Centre] clinic and I've taken my patients there, but I don't do that anymore because there's no reason to," Faber says. "We have everything – there's no reason to go to the private sector."

Modernized Information Systems

Interior Health Authority's Redesign of Surgical Services

With an area population of about 700,000, the Interior Health Authority (IHA) serves 54 communities and 35 acute care facilities across a sprawling region of BC's southern interior, stretching from Williams Lake in the north to the US border in the south, and from Anaheim Lake in the west to the Alberta border in the east.

Three years ago IHA had six operating room booking systems at nine sites. Now one system serves 11 sites.

The scheduling of patients for surgery is a far from simple task. In fact, a 2004 review of IHA's surgical services by Sullivan Healthcare Consulting – the first ever done – stated: "The scheduling of surgical patients is one of the most complex non-clinical activities that can occur in the hospital. The goal of a scheduling/booking program is to bring all the necessary resources together at the same time and place while communicating expectations to everyone involved, and balancing cost, utilization, and convenience."[21]

The surgical review identified three major problems with IHA's former booking system: inconsistent practices, inconsistent implementation of medical information, and the fact that different surgeons and sites used different names for the same procedure. In other words, when people needed to discuss which doctor performed which operation on whom, when and where, they were in a Tower of Babel – not everyone spoke the same language. Without accurate information about resources, management cannot ensure that health care delivery is sustainable, accountable and centred on patients.

The 2004 Sullivan review recommended that IHA standardize its entire peri-operative management system (the time surrounding a person's surgical procedure, including admission, anesthesia, surgery and recovery). The health authority decided that modernizing the operating room booking system

was the number one priority in that process. As a result, by November 2006 all surgical facilities capable of electronic booking had installed the *Picis OR Manager* software program. The cost to the public health care system was not onerous – just $1.5 million out of a total budget of $1.25 billion – and the change took only 18 months to implement.

IHA project leader Janine Johns describes the effort as "huge." Although there has been some resistance, Johns says once booking clerks and nurses get accustomed to the new program, it will make their work easier and give management the tools to "look at how we do business instead of looking at a bunch of numbers that don't agree."

One simple but far-reaching improvement is the electronic recording of surgeons' "preference cards," necessary because surgeons have their own way of doing procedures and their own preference for equipment. Previously, information was kept in notebooks, on bits of paper, or in a particular nurse's memory, assuring lost time and energy if the paper was lost or a nurse was off-duty. Now it's all in the system.

In addition to easing practices for health care workers, the new booking system also benefits patients. "They won't get lost," Johns says. "It will lead us to the point where we can better plan when and where to have our services."

When patients are fully prepared and informed about their surgery, there are fewer delays or cancellations, better outcomes, better use of surgical resources and reduced wait times.

Another critical element in IHA's surgical redesign is the establishment of a pre-surgical screening program (PSS). The IHA 2004 Surgical Services Review states that pre-surgical screening offers a greater "return on investment" than any other recommendation made in the report.[22] That's because when patients are fully prepared and informed about their surgery, there are fewer delays or cancellations, better outcomes, better use of surgical resources and reduced wait times. IHA has now implemented PSS for about 75 per cent of elective surgical cases. Its goal is to screen every elective surgical patient before surgery.

Johns says none of this would have happened without the remarkable teamwork that emerged between managers, nurses and particularly physicians. IHA's surgical council is a mix of administrators, nurses, surgeons and anesthesiologists, with the majority being physicians. Their project team has two paid physicians – one surgeon and one anesthesiologist – and a surgeon chaired the committee that guided the implementation of the new OR booking system.

"I don't know of any other health authority where physicians have led these types of initiatives for a health authority implementation," Johns says. "It's the commitment of these guys, and the commitment of key surgeons and administrative leaders in Interior Health, that has got us to this point, and in addition to dollars, we think this is the most important aspect of our success."

Full integration and improvement of surgical services, however, demands action in several other priority areas, including safety and standards, staff roles and ensuring appropriateness. One big step in the right direction is IHA's participation with other BC health authorities in the provincial government's new and still evolving Provincial Surgical Services Project (see page 23).

As for the other priorities, Johns says the ability to move forward depends primarily on two things: recruiting and retaining staff, particularly nurses, and having secure funding. The first phase of the surgical redesign received one-time funding that runs out at the end of the fiscal year (March 31, 2007). The next phase will have to compete with all other IHA programs.

"I'm excited with what we have built," Johns says, "but will we have enough dollars and people to continue moving forward?"

Ironically, while Johns remains uncertain about prospects for long-term funding to support the surgical registry, the Interior Health Authority has issued an RFP (Request for Proposal) for a private surgery clinic with a guarantee of 10 years funding for a minimum of 1,700 cases annually. However, in a January budget announcement for 2007/08, the provincial government would commit only to one year of funding for health authorities.

Although private interests may be able to establish a health clinic quicker than their counterparts in the public system, the existence of such a clinic creates several problems (see *Why Not Go Private?* on page 12). First, it lures precious health care workers, in particular nurses, away from the public system where they are desperately needed. Second, depending on the clinic's contract, its existence could compromise the effective management of the waitlists of doctors who practice in both public and private facilities. Finally, a privately-run surgical centre will likely serve only low-risk patients, leaving the more complex and acutely ill patients for the public system to care for. Yet if the private clinic is paid the standard rate per case, the public system could end up overpaying the clinic for its services.

Surgical Efficiencies

The surgical process – a person's pre-operative tests, hospital admission, anesthesia, surgical procedure and recovery – is one of the most complex parts of patient care and consumes the bulk of a hospital's budget. Drawing on nearly every area of the hospital, from radiology to laboratory to nursing to medicine to administration, surgical practices determine a hospital's ability to operate safely and efficiently. Cancelled, delayed or inefficient surgeries not only cost the system money, they increase bed utilization, back up emergency departments, decrease patient safety and staff morale, and increase frustration for everyone involved.

As the projects profiled in this report show, there are a wide range of relatively simple, common sense and often inexpensive ways to make the surgical journey more efficient. They include:

- Pooling patients onto a common waitlist. This simple step has immediate and dramatic benefits because it allows patients to see the next surgeon available. It does not, however, prevent them from seeing the surgeon of their choice.
- Pre-screening and educating all patients facing surgery. This not only means identifying high-risk patients well before surgery so that anticipated complications can be addressed, but providing support to those who need to make changes such as quitting smoking. It also involves co-ordinating all pre-op analysis such as blood tests, X-rays and opportunities to assess appropriateness.
- Discharge planning before surgery. Ensuring that home care arrangements are in place decreases the chance patients will need re-admission.
- Beginning all surgeries on time, particularly the first one of the day, lessening the chance of back-up.
- Standardizing surgical equipment by procedure rather than by surgeon. This makes assisting operations easier and allows for bulk buying of equipment. When appropriate, physician preference information needs to be current and easily accessible.
- Booking groups of similar procedures together. This enhances efficiencies, allows staggering of OR start times, and streamlines patient flow. For instance, one surgeon starts a case at 2:15 p.m., while another starts the same procedure in a room across the hall at 3 p.m. The surgeons or surgical assistants can move back and forth to help each other with incisions and stitching up and closings while cleaners are ready to sanitize the rooms when each case is over.
- Modernizing electronic information systems so that physicians, hospitals and health authorities can access accurate, consistent and up-to-date data on patients waiting for surgery and so better manage their surgical process.
- Standardizing patient care protocols to ensure all patients receive the best post-operative care. For example, helping patients stand or walk a few hours after surgery instead of the next day, or ensuring that patients receive adequate pain management.
- Supporting advanced practice registered nurses and nurse practitioners who can be trained for such roles as anesthesia or surgical assistants.

Improved Waitlist Registries

BC's Surgical Patient Registry

BC's current Internet waitlist registry is inaccurate and inconsistent and thus difficult to use as a management tool. On the whole, information on surgical services in this province is out-dated, as it is elsewhere. But BC is in the process of changing that situation. Two years ago, the province launched the Provincial Surgical Services Project (PSSP), an ambitious collaborative effort between the Ministry of Health, the province's six health authorities, practicing surgeons, the BC Medical Association, UBC's Faculty of Medicine and the BC Medical Services Commission. While the project is co-coordinated by the Provincial Services Health Authority (PHSA), it has no designated provincial leader.

The goal of the PSSP is to reorganize surgical care to make it fairer, timelier and more appropriate for patients. After more than two years and $5 million in capital funding, its new BC Surgical Patient Registry (SPR) is approaching completion. This real-time, web-based registry is capable of reliably tracking all patients waiting for all elective surgeries in BC. Modeled on Saskatchewan's successful registry (see Saskatchewan Surgical Care Network on page 27), BC's version had to be significantly modified for a much larger, busier population.

"The goal is to dramatically reduce waiting times," says Brian Schmidt, PHSA senior vice president for provincial services, public and population health, and leader of the PSSP steering committee. "And if we can't deliver accurate information, we'll never get it right."

The new Surgical Patient Registry has been successfully piloted and promises to have huge advantages over the current system. As Schmidt says, "we'll be able to compare apples with apples." The project hoped to have the registry fully up and running by the end of March 2007, but due to a slower than anticipated consultation process between BC doctors and SPR leaders is now aiming toward the end of

the year. Unlike their counterparts in Saskatchewan and Ontario, the BCMA had a significant hand in shaping the registry. Doctors in this province negotiated the conditions determining how the registry information can and cannot be used. Those conditions underlie nine BCMA-forged principles, the details of which are not publicly available.

At stake is exactly how information gathered through an electronic form, called a "clinical prioritization tool," will be used. The tool is meant to enable health authorities, together with surgeons, to ensure that those who need surgery most get it first. As such, it will affect some surgeons' work patterns. Surgeons working with PSSP have developed these tools for 13 surgical specialty groups, such as orthopaedics, ophthalmology and neurosurgery. One specialty remains to be finalized.

BCMA President Elect Dr. Geoff Appleton says the nine principles include conditions that the registry be publicly accessible, guarantee patient privacy and ensure "physician independence."

"There are two or three [principles] that basically surround the surgeon-patient relationship that we want to keep intact," Appleton says.

The agreement also includes an incentive of $4 million over two years from the provincial government to compensate surgeons for time spent filling out clinical assessment forms. Appleton says by the end of December, BC surgeons will complete a clinical assessment tool as a condition of having their patients placed on the provincial registry.

Now, only about one quarter of surgeons in the province contribute to the registry. All surgeons performing publicly-funded procedures, whether in private or public facilities, are eventually expected to take part.

On a positive note, Schmidt says the provincial government has assured him that the SPR will receive funding for next year. Also positive is the fact that surgeons will have to participate in the registry in order to book surgery. However, at this point it appears that the registry will not be as pro-active as those in Saskatchewan and Ontario (see pages 27 and 29). And, if that turns out to be the case, it could compromise BC's efforts to implement progressive health care reforms.

IN SUMMARY, WHILE THERE ARE A NUMBER OF OUTSTANDING INITIATIVES IN BC TO REDUCE WAIT times for elective surgeries, provincial leadership has not appeared. Many of these projects exist in pockets of the system rather than throughout its entire fabric. Even the Provincial Surgical Services Project, which is nominally a provincial initiative, is fundamentally a responsibility of individual health authorities working within the principles set out with the BCMA, rather than of the Ministry of Health. That's why, in terms of moving toward full provincial implementation, it is necessary to turn to initiatives in other provinces.

Public Sector Innovations Outside BC

Alberta Hip and Knee Replacement Project

As the above examples illustrate, BC has reason to be proud of its efforts to renew public health care. Of the several initiatives in other provinces also worth attention, none is more deserving than the Alberta Hip and Knee Replacement Project, a joint effort by the Alberta Bone and Joint Health Institute, orthopaedic surgeons, health regions and the Alberta government. Heralded across the country as a prime example of how relatively simple, common sense changes can solve seemingly intractable problems, the now-completed year-long pilot project combines elements of North Vancouver's JRAC and the Richmond and UBC hip and knee reconstruction projects. It then adds even more progressive ideas. The project is now the standard of care for hip and knee replacement in the Calgary, Capital and David Thompson health regions, and three other regions have expressed interest in adopting the model.

The pilot project was jump-started in April 2005 with a $20 million grant from the Alberta government. Its model of care is built on the concept of stand-alone, community-based care, with central clinics functioning as one-stop shops for assessment, diagnosis and treatment. Clinics are located in Edmonton, Red Deer and Calgary.[23] Patients arrive already having been partially "worked up" by their family doctors, who complete a two-page referral template covering such things as patient history and past treatments. Patients are given the option of going with the first-available surgeon or a surgeon of their choice. The template also allows family doctors to alert the orthopaedic surgeon or clinic if the patient is an urgent case.

At the clinic, a multidisciplinary team assesses patients for their need and/or fitness for surgery. If changes need to be made before surgery (such as losing weight or quitting smoking), supports are provided. If patients are worried about how they'll cope after surgery, home care services are arranged prior to their operation. Patients are matched with a case manager who helps navigate them through

the process. The result of all of this up-front work has been dramatic reductions in total wait times, delays and last-minute surgery cancellations. As a recent Canadian Institute of Health Information study revealed, hip and knee replacement patients spend nearly one-third of their overall wait time waiting for their first visit with an orthopaedic surgeon.[24]

The Alberta project boasts of another simple but potent action. At the start of the health care journey, all patients sign a contract making them full partners in that process. That's because one of the core tenets of the project is that we are all responsible for improving our health care system. Project leaders argue that the public needs to do more than just hope someone is looking after their best interests. The project encourages patients to ask questions and expect answers, and in so doing "be held accountable at an individual level for their own care and for the success and failures of our health care system."[25]

Using the best evidence in the world for hip and knee replacements, the project standardized all aspects of care, from operating equipment to post-operative pain management to frequency of follow up visits. All services are continually evaluated for access, quality and cost. The model incorporates two other benefits: public release of all performance reports and an arrangement whereby publicly-funded services that are not supported by medical evidence lose their funding, with funds being redirected to evidence-based public care. Ideally, the system will move to that level.

Physicians have a long history of independent practice. That makes them reluctant to change their practices until they see evidence that doing things differently is better.

Dr. Cy Frank, co-vice chair of the Alberta Bone and Joint Institute and one of the project's architects, says the goal was to reduce variations to make the system as predictable as possible. For example, Frank, who is also a University of Calgary professor, says in a sports medicine setting he found that each of the seven surgeons doing arthroscopy (the insertion of a small telescope into a joint to permit visualization of the structures) did the procedure differently.

"They were all using different drapes, different instruments," Frank says. "Then we told them their numbers and asked how they can justify this. Within a month they all gravitated to within 10 per cent of the lower case costs."

If and when this model becomes established province-wide, Frank foresees potential cost savings to the whole system because, he says, best practices cost less. The trick is how to take the project to a larger scale. Physicians have a long history of independent practice. That makes them reluctant to change their practices until they see evidence that doing things differently is better. The project measured everything: total wait times – from the moment a family doctor advises a patient to see a surgeon until a year after the surgery – to patient outcomes, patient satisfaction, safety, compliance and quality of life. The interim evaluation revealed:

- Wait times from first referral from a family doctor to a first visit with an orthopaedic surgeon dropped 80 per cent, from over eight months to just six weeks. These improvements at the front end were responsible for 41 per cent of the overall reduction in wait times.
- Wait times from first visit with an orthopaedic surgeon to surgery plummeted 90 per cent, from 11 months to 4.7 weeks.

- Length of stay in hospital fell 30 per cent, from six days to four.
- Patients surveyed expressed increased satisfaction.

Despite the obvious benefits to patients, and the fact that the program's surgical roster has more than tripled (from 13 to 45 participating surgeons), it continues to face resistance from some physicians. Some balk at the inconvenience of having to set up and run a second office in the community clinics. Others oppose the model because of a deep-seated affinity in medical culture to practice solo.

"Our system has gravitated to independent practices where everyone does things their way. There is resistance to change because everyone believes doing it their way is the best way. But with evidence, people will accept a common way. Surgeons who weren't part of the project now want to be part of the new way. They are changing voluntarily because we have the evidence." Frank explains.

The challenge is to attract more surgeons by making the model more effective and efficient for them. As for public funding, Frank says the institute is working closely with health regions for further service agreement contracts.

"I am very optimistic," Frank says. "This is the thin edge of the wedge to changing the system to focus on access, quality and cost – they are all linked. We already have a great system and we can do better."

Saskatchewan's Surgical Care Network

The Saskatchewan government was the first in the country to establish a province-wide system to rate and follow all patients waiting for all surgeries. Launched in March, 2002, the Saskatchewan Surgical Care Network (SSCN) is the most comprehensive surgical database in Canada and the foundation for several other provinces currently implementing their registries. What makes it so laudable is its pro-active rather than passive nature. Traditional surgical waitlists post numbers of patients waiting for particular surgeries on the Internet. That's about all they do. The hope is that patients viewing the list move to a surgeon who has shorter waits or that surgeons with long lists suggest patients move to another surgeon. But neither scenario tends to happen. Patients are extremely reluctant to switch doctors on their own and surgeons rarely share lists. A further problem is the outdated, inconsistent and unverifiable data on passive waitlists – a product of variable reporting methods. Studies have shown that more than 30 per cent of names on waitlists are not valid because they are either duplications, or list patients who no longer need surgery, have moved, had the procedure or died.[26] Most significant, passive registries hold no-one accountable for using the data to actively shorten wait times.

Pro-active registries, on the other hand, start with firm and daily-updated data gathered in a consistent and standardized way. This information can then be used by patients, physicians and more importantly health authorities to shorten wait times for care. Active registries are more about *managing* wait times than they are about *reporting* wait times. It must be emphasized, however, that no registry and no waitlist – active or passive – prevents patients from choosing a specific surgeon. Patients always have the right to choose who will perform their particular procedure. However, depending on their choice, they may have to wait longer.

Peter Glynn, founding chair of SSCN and co-chair for the past five years, who is also a Kingston-based consultant on health care policy, planning and governance, says the registry was triggered by the realization that when it came to waitlists nobody had accurate data and so no one agreed on what to do.

Wait times were discussed in an environment where "everyone was using opinion, conjecture and nobody had any facts," Glynn says. "Our goal was to get the facts and be able to measure and monitor and, most importantly for the health authority/hospital, to manage access using information on who is waiting for what."

Previously, individual surgeons kept that information filed anywhere from computers to index cards. Improvements began to appear when government gave health authorities the technology, the standardized rules and the consistent prioritization criteria to produce firm and factual data. That in turn obligated them to be accountable for ensuring patients receive timely care. Defining who is in charge, Glynn emphasizes, was key. Although surgeons are intricately involved in all aspects of the process, regional health authorities are now expected to manage access in partnerships with surgeons. Equally important, surgeons must participate in the registry before they can book their operations in hospitals. Most important of all, this new accountability arrangement is backed up by provincial legislation. While there is some angst on their part, surgeons have seen that if they operate efficiently and their patients still wait too long, government will provide money to deal with that issue.

No registry and no waitlist – active or passive – prevents patients from choosing a specific surgeon. Patients always have the right to choose who will perform their particular procedure. However, depending on their choice, they may have to wait longer.

Says Glynn: "This is about patients." Every health authority in Saskatchewan has a surgical care coordinator. Patients can phone designated contacts and find out where they stand on the list, which surgeons in their region or elsewhere in the province have shorter lists and what their assessed priority level is. Traditional classifications of priority use the terms emergent, urgent and elective. But not everyone understands or uses those terms the same way. The new system, created by a committee of physicians and other health care workers, assesses patients and places them in one of five categories, each of which is assigned a target time frame. For example, emergency patients are to be treated within 24 hours, while 90 per cent of Level 1 patients – those with the second highest level of need – are to be treated in three to six weeks.

The SSCN provides a range of information, including wait times and waitlists, physician location and physician specialty. Since it began, waits measured from the time of decision for surgery to the time of surgery have declined steadily while the numbers of surgeries have gone up. Once the decision to operate is made, half of all patients wait less than five weeks, and more than 80 per cent wait less than six months.

Still, some Saskatchewan patients continue to wait too long, particularly for orthopaedics, plastic surgery and ophthalmology. The province's biggest challenge now is how to implement further initiatives while struggling with the world-wide shortage of health care workers. Glynn says some of those problems can be addressed by doing things differently, such as reducing lengths of stay in

hospital and expanding some roles, such as training nurse anesthetists. Government is also looking at ways to reduce hospital occupancy rates by increasing the number of day surgeries.

Given that former Saskatchewan premier Tommy Douglas is credited for founding Canada's universal health care system, the prairie province's leadership position in health care reform is most fitting. But like other jurisdictions, it has a lot more work to do. Glynn says improvements in health care system efficiencies are still far behind those used in industry for many years. Nevertheless, he has seen that when the public system implements similar improvements it can gain similar efficiencies.

Ontario's Wait Time Strategy

In 2004, Ontario launched its Wait Time Strategy (WTS), an ambitious, almost billion dollar, multi-pronged effort to reduce wait times. While that amount sounds huge, it represents only about 3 per cent of Ontario's health care budget. The province has targeted five high-demand areas: cardiac revascularization procedures, cancer surgery, cataract surgery, hip and knee joint replacements, and MRI and CT scans. The strategy's first goal was to reduce times for 90 per cent of patients waiting for treatment in those areas by December 2006. That goal has been achieved, albeit more successfully in some areas than others. According to the government's latest update (September 2006), it met all targets for cancer and cardiac bypass surgery, but has not yet for other areas.[27]

It is important to look at how much of these improvements are due to the dollar deluge and how much to genuine improvements in system efficiency. After all, research offers many examples of how money alone has failed to sustain improvements, and even in some cases made things worse by, for instance, encouraging unnecessary surgeries.[28]

"In the beginning it's simply cash buying more cases," says WTS lead Dr. Alan Hudson. "But as you move along you get more and more efficient because as you start getting more reliable data, you can start managing better."

These early wait time reductions are only the first step in what promises to be an ambitious and lengthy journey forward. Ultimately, the WTS aims to markedly improve access and reduce waiting times for a far wider range of services well beyond the end of last year.

As Hudson says, "This is not about wait times. It's about totally introducing new systems of care for Ontario."

Such a monumental task requires an equal amount of commitment and cooperation from government, hospital boards, health care providers, the public, and Ontario's new regional coordinating structures, known as Local Health Integration Networks or LHINs. As WTS leaders recently wrote, if the government-led initiative is to succeed it must activate, develop and support "a behavioural shift that makes everyone responsible for achieving wait times results."[29]

The following elements are fundamental to Ontario's WTS plan:

- FOCUSED DOLLARS. Over the past two years Ontario has devoted an additional $614 million for about 657,000 additional medical procedures. If bulk purchases of MRIs and CTs are included, spending approaches $1 billion.

- ACCOUNTABILITY. Hospital boards are now accountable for managing access. In order to receive additional case funding, they must sign a contract to that effect. Hospitals that do a greater number of surgeries receive more money, contrary to most traditional arrangements where more procedures result in increased costs to hospitals.[30]

- INFORMATION TECHNOLOGY. Standardized data collection is producing a single waitlist allowing management to track, monitor and improve access while giving patients the ability to compare wait times with those across the province. The effort involved switching from 150 IT systems province-wide to one. The system now collects about 80 per cent of provincial surgical waitlist data with the participation of about 60 per cent of Ontario surgeons.

- PERI-OPERATIVE COACHING TEAMS. Usually made up of an experienced operating room nurse manger, an anesthetist and a surgeon, these teams advise operating room, medical and hospital staff how to become more efficient. The first round was voluntary, but now government sends in coaching teams whether hospitals ask for them or not.

As impressive as the strategy's first milestone is, it faces many obstacles. With a provincial election set for October 2007, the WTS has become a sensitive and hotly-debated political topic. Critics point out that information on patient outcomes, appropriateness of surgery, and quality and safety of procedures has yet to come. This information is vital for any true evaluation – doing more surgeries faster does not necessarily mean doing them better. Also delayed is full participation by the 14 LHINs, which now have the legal status to be regional overseers of the process. As if that weren't enough, the strategy is hampered by the pervasive shortage of non-physician health care workers, in particular nurses, nurse practitioners, respiratory technicians and MRI technicians.

Although Ontario's experiment may not be unfolding as completely or as quickly as planned, its efforts are unprecedented and its accomplishments are many. The strategy is about to tackle wait times for all general surgery, all orthopaedics (not just hip and knee replacements) and all ophthalmology (not just cataract surgery). A WTS-contracted report by the Institute for Clinical Evaluative Sciences (ICES) on the appropriateness of imaging services will be out shortly, Hudson says, adding that appropriateness studies on imaging could eliminate wait times for these services altogether. (For example, 90 per cent of imaging studies for headaches are negative, he says.)

There's no doubt that Ontario has created a momentum of change. The challenge now is to ensure that these initiatives promote quality outcomes, ways to measure appropriateness, and collaboration within a publicly funded and delivered system.

Beyond Waitlist Management

Although the practice and policy changes discussed in this paper may initially seem onerous, other jurisdictions have proved they are not. They represent a significant step toward eliminating unreasonable waits for care, but they are only the first of several. A critical yet frequently ignored contributor to long waitlists is the dynamics of hospital use. Long term solutions must be found to take the pressure off hospital services so they can respond to fluctuating demands for acute care while simultaneously meeting their elective surgery targets. In fact, according to a recent position paper by the Canadian Association of Emergency Physicians, upwards of 20 per cent of hospital beds are occupied by patients who would be better off cared for in a long-term care facility or at home with quality home care.[31]

Emergency overcrowding is very much related to hospital occupancy rates. A recent British study found that when bed occupancy rates exceed 85 per cent, risks to patients increase, and acute care hospitals experience regular bed shortages. When occupancy rates rise to 90 per cent or more, bed crises result.[32] In the Canadian experience, more often that not, bed crises result in cancelled elective surgeries. Making matters worse, is the scarcity of community-based clinics that are open 24/7. This results in many people with non-urgent problems using emergency departments.[33]

Another British report noted that the single most important way to improve wait times in emergency and to reduce the number of cancelled surgeries is to ensure more beds are available. And one of the main ways to guarantee more beds is to improve community care.[34] Yet BC has moved in the opposite direction. According to a 2005 report by the Canadian Centre for Policy Alternatives, access to long-term care and home health services decreased significantly between 2001 and 2004, in spite of an aging population and cuts to the acute care system.[35] Thus, expanding community health care represents another vital means of taking pressure off the more expensive acute care system and enhancing the flow of elective surgeries. Ways to do this within the public system will be further explored in a forthcoming CCPA report.

Conclusion

There is no quick and easy solution to shortening wait times. As this paper demonstrates, it takes hard work and a willingness to abandon long-held habits.

As this report also shows, there are people in the public system intensely engaged in doing just that. People at all levels are marshalling a range of strategies that – slowly in some places and more quickly in others – are transforming health care. Especially encouraging are initiatives such as the Richmond Hip and Knee Reconstruction Project, North Vancouver's JRAC and the Alberta Hip and Knee Replacement Project. These efforts have proved their worth. According to the Canadian Institute for Health Information, surgical teams across the country performed 40,000 more operations last year than in 2005 in waiting-time priority areas. In one year, hip and knee replacements jumped 12 per cent and cataract operations rose 10 per cent. Even non-priority areas such as non-cataract eye surgery and other orthopaedic surgeries increased significantly.[36] This good news, commented a cautious but optimistic Globe and Mail editorial, may not be definitive proof that the system is more efficient, but it does suggest that "medicare is turning the corner."[37]

While those involved in these projects and others know how to keep that momentum going, the key question in BC is whether government will follow their lead. The champions of public sector reform need help. Given the absence of any national health human resource planning, they work in the midst of an ongoing shortage of health professionals, and although reforms will not resolve that shortage, they can partially alleviate it by allowing workers to take on expanded roles, increasing efficiencies and testing patients for appropriateness and thus decreasing demands for surgery.

The health care system is extremely complex. On the one hand, it is an often discordant mix of provincial-federal politics, professional turf wars, corporate battles and academic positioning. On the other, it is made up of highly-skilled, compassionate and committed teams of professionals engaged in a treasured Canadian tradition – furthering the public good. Reality, of course, includes both these scenarios.

If patient-centered care is a priority, it's clear which side of the equation must prevail. The BC government must take a leadership role and declare who it will support. Right now that choice is not clear. When Premier Gordon Campbell announced BC's Conversation on Health, he suggested that public involvement in health is no longer financially sustainable, implying that we should consider a larger role for private insurers and private providers. But is that what British Columbians want? More

to the point, does the evidence tell us that for-profit schemes such as contracting out and private day surgery clinics provide better care to the majority of people? To the contrary, the evidence shows that private, for-profit services cost society more, are less safe for patients and compromise the public system. Additionally, in our view there is considerable reason for concern based on the government's recent support of Canadian Medical Association president-elect Brian Day's proposal for a new funding model for hospitals based on UK style reforms. These concerns are discussed in the Appendix.

The BC government needs to shift direction and instead of promoting private clinics, become the steward of public waitlist reform. They can do so by:

- Replicating and expanding on the successes established in North Vancouver and Richmond/UBC by providing dedicated resources and oversight so that these initiatives become the rule rather than the exception in BC. Although most of these projects pertain only to hip and knee reconstruction, there is no reason the efficiencies they employ can't be expanded to a range of surgical specialties.

- Shifting accountability for ensuring smooth surgical flow and waitlist management from individual surgeons to a regional group of surgeons, and from individual hospitals to health authorities. As noted throughout this document, most Canadian waitlists are managed by individual surgeons who view this role as part of their traditional professional autonomy. Shifting responsibility for waitlist management from individual surgeons to health authorities working with groups of physicians and other health professionals is a huge cultural change that some surgeons may resist. Given that probable opposition, the provincial government must take charge because, as this paper consistently shows, managing waitlists based on the needs of patients in an entire region significantly reduces the time people spend waiting. In Canada this has most effectively been done in Saskatchewan where there is provincial leadership and resources, and where regional leaders ensure that standardized rules and evidence-based practices are used to manage the registry. In Ontario, peri-operative coaching teams made up of nurse managers, anesthetists and surgeons are intent on achieving similar goals.

However, the recent agreement between the BCMA, the BC Ministry of Health and health authorities may significantly limit the province's ability to rectify the waitlist problem. While this paper features physicians who are actively engaged in real system change by, among other things, working in teams, the agreement appears to leave much of waitlist management and coordination to individual physicians. It also appears to restrict the ability of health authorities to re-direct patients. If there is no transfer of accountability to groups of surgeons responsible for managing waitlists along with health authorities and other health professionals, not much will change. Yet the benefits of team-based care – to patients and to the system as a whole – are overwhelming.

In effective public sector and private sector organizations, senior leaders set specific conditions of employment to maintain quality and efficiency standards. When it comes to efficiency and effectiveness, public health care is no different. Where are the leaders our health care system so urgently needs? Will the BC government take up the challenge of actively managing waitlists through its health authority partners or will it throw up its hands as it has done recently and declare that the public health care system is simply "unsustainable"?

We hope this contribution to the Conversation on Health will persuade the government to give British Columbians the right answer to that question.

APPENDIX

Undermining Recent Waitlist Gains in BC: Brian Day's Proposal for a UK-Style Competitive Market in Health Care

While research for this paper was underway, a new proposal for how to address waitlist issues was put forward by Brian Day, President-elect of the Canada Medical Association, owner of a private surgery clinic and outspoken advocate for private delivery. Day's proposal has the attention of the provincial government, with the Premier, Finance Minister and Health Minister all expressing a keen interest in his ideas.[38] Day's proposal calls for the creation of a competitive market in health care based on recent reforms in the United Kingdom, where public National Health Service (NHS) hospitals must compete with each other and with private surgery clinics for patients and funding. In Canada, this model has variously been called "activity-based funding," "service-based funding" and "patient-focused funding." In the UK, it is known as "funding by results."

What are the UK Reforms?

Three UK reforms have created market-like conditions in health care. The first was the decision in 2003 to provide public funding for private surgery clinics, otherwise known as Independent Sector Treatment Centres (ISTCs). The second was a shift from a globally-funded system in which NHS hospitals received a guaranteed level of funding each year, to a "results-based" funding model where funding is provided only after the fact based on the volume and type of service provided (the implementation of this new model began in 2004 and will be fully operational by 2008). The third change was a new "patient choice" model introduced last year, whereby family doctors were mandated to offer patients requiring planned (i.e. elective) hospital care a choice among four or more hospitals, one of which could be a private surgery clinic (ISTC). As a result, public hospitals now compete with each other and with private clinics for patients. In November, public hospitals received approval to advertise their services using celebrity figures.[39]

Ironically, the private clinics or ISTCs are not funded using this new "payment by results" model, but instead receive guaranteed levels of funding no matter how many patients they serve. In other words, while NHS hospitals must now compete for patients to ensure an adequate revenue stream to stay out of debt, private clinics are assured stable funding levels until at least 2008. It is also important to note that, as part of this reform package, government increased the overall funding for health care by

7 per cent each year for five years – from March 2002 to March 2007. These higher levels of funding have made it possible to make some reductions in waitlists.

The stated goal of these reforms is to improve efficiency and reduce waitlists through the creation of a health care market. As Day put it in a recent column for the Vancouver Board of Trade, if this new form of funding results in some less efficient hospitals closing down, then "so be it."[40] But does it make sense to close down hospitals given the shortage of hospital beds in BC? Does it not make more sense to develop collaborative strategies (among hospitals and health authorities) to improve efficiencies in poor performing hospitals? Are collaborative strategies even possible in an environment where hospitals are competing against one another for patients, and patients are asked to choose a hospital based on information from celebrity or other ad campaigns?

Arguments Against UK-Style Reforms

Since these reforms came into effect, a number of professional organizations and academic journals in the UK have raised alarm bells. A 2005 study published in the British Medical Journal on the implications of the "payment by results" financing system warned of the potential danger of over-servicing (i.e. providing unnecessary care).[41] In a comparison of short-stay emergency admissions between hospitals that had introduced the new funding arrangement and those that had not, researchers found more admission in hospitals with "results-based funding." The explanation – short-stay admissions attract higher payments (under the new system) than outpatient emergency care, so hospitals have an incentive to increase admissions.

In the area of administrative overhead, there is also evidence of rising costs and a reduction, rather than increase, in system efficiency. A study published in Health Policy comparing transaction costs before and after the introduction of "payment by results" found that, while costs per procedure went down, overall costs went up.[42] This was due to the higher costs for price negotiation, data collection, monitoring and enforcement with "payment by results," as each procedure had be priced, checked, recorded and rechecked.

In addition to higher administrative costs and over-servicing within the NHS, questions related to quality of care and costs in the private clinics have been raised. In the main body of this report there is a reference to concerns raised by the College of Surgeons and the British Medical Association (BMA) about the quality of care in ISTCs and the higher public hospital readmission rates from private ISTC clinics. On the cost side, the Department of Health has acknowledged that procedures purchased in the private ISTC cost on average 11.2 per cent more than the NHS equivalent services.[43] A House of Commons report on ISTCs suggests that the costs of contracting with the ISTCs could be even higher, but because contracts are subject to commercial confidentiality no one knows for sure.[44]

A cornerstone of the new UK system of payment is "choice." This is yet another area where serious shortcomings have been identified. A study commissioned by the UK Department of Health (DOH) found that people did not want to select a hospital while they were seriously ill, preferring that such decisions be made by a trusted family doctor. The study concluded that there was no evidence that greater choice would improve quality of care, and good reason to fear that it would benefit only the wealthy and articulate. According to the BMA, the report, which discredited government policy on choice, mysteriously disappeared from the DOH website.[45]

The BMA's opposition to this new competitive model was clearly articulated at its 2005 annual meeting when delegates passed a unanimous resolution that "more emphasis should be placed on collaboration as opposed to competition."[46] Chris Ham, a professor of health policy at Birmingham University and former director of strategy at the Department of Health (2001–2004), made a similar observation in a recent article in the Guardian. Ham noted,

> *With healthcare organizations competing with each other for a bigger share of the NHS budget, there is little incentive for them to collaborate and to substitute care in the community for care in hospitals.*[47]

Ham goes on to say that the new funding system does not incorporate the incentives needed to improve productivity and performance, and he predicts that without a change in policy the NHS will not survive as a universally tax-funded service.[48]

An early report on "payment by results" from Audit Commission (an agency similar to our Auditor General) makes an equally negative prediction. It warns that the uncertainty of funding under the results-based system will increasingly destabilize NHS hospitals.[49] Evidence of rising levels of instability within the NHS over the last year or more can be seen with rising levels of debt in NHS institutions, service cuts and recent announcements of pending hospital closures.[50]

Implications for BC

Based on the evidence from Britain, there is every reason to fear that Day's proposal will undermine rather than ensure the sustainability of the public health system in BC. The efficiency gains made in recent waitlist strategies in BC and elsewhere in Canada depend on more – not less – collaboration. Having multiple hospitals and clinics compete for the same procedures constitutes a move in the opposite direction. Our report outlines a number of ways of achieving efficiency gains: by ensuring better coordination of waitlists across a region, developing multidisciplinary community clinics and processes for sharing best practices as well as coaching programs to support hospitals where waitlists are longer. But Day's proposal represents a disincentive for hospitals and clinics to engage in such cooperation.

This is not to say, however, that the current funding model for hospitals in BC is problem free. There is clearly a perverse incentive embedded in the global funding model, whereby hospitals manage to stay within budget by closing operating rooms and beds. There is certainly merit in looking to a new funding model that rewards hospitals for doing more, not less, as long as the model takes into account the benefits of community-based team care and is guided by the principles of collaboration, quality and appropriateness. It is an area where further work is required, work that builds on the waitlist successes in BC and elsewhere, and focuses on sustaining rather than undermining public health service delivery.

Notes

1 Health Canada, 2006.

2 Postl, 2006; Rachlis, 2005.

3 Romanow, 2002.

4 Lee, 2006.

5 Wright, 2002.

6 Postl, 2006.

7 Canadian Health Services Research Foundation, 2005.

8 Tuohy et al., 2004.

9 Armstrong, 2000; Lomas, 2007.

10 Gonzalez, 2004.

11 Devereaux et al., 2002.

12 Garg et al., 1999.

13 Devereaux et al., 2002.

14 House of Commons, 2006.

15 Zocia, 2006.

16 Dyer, 2004.

17 Lang, 2005. A 2004 comparison of Canadian and US hospital costs also found wide disparities. Total hip replacement in Canada was $6,080 compared to US$12,846. See Antoniou et al., 2004.

18 Shimo, 2006. The article lists hip replacement surgery at US$19,000.

19 Canadian Institute for Health Information, 2005a.

20 Shimo, 2006. Prices may include hotel for an accompanying family member for up to four nights, but do not include travel costs. Residents of BC pay less because the surgeon's fee is paid by the provincial health plan, a practice which is illegal under the Canada Health Act if a physician is also charging private payers.

21 Sullivan Healthcare Consulting Canada Co., 2004.

22 Interior Health Authority, 2004.

23 Some say the project's success depends on use of Calgary's private surgical clinic Health Resource Centre (HRC). But while Edmonton and Red Deer have available space in public facilities, Calgary does not. The project was forced to contract HRC for some of their space and operating room costs. All physicians and other health care providers are paid through the public system and each region receives the same amount of money per case to cover facility fees.

24 Canadian Institute of Health Information, 2006.

25 Frank et al., 2006.

26 Health Council of Canada, 2005.

27 One year after September 2005, wait times in the five priority areas had fallen by 33 per cent for cataract surgery, 19 per cent for knee replacement surgery, 21 per cent for hip replacement surgery, 54 per cent for angiography (a type of X-ray of the blood vessels or chambers of the heart), 29 per cent for angioplasty, 6 per cent for MRI scans, and 14 per cent for CT scans.

28 Harrison and Appleby, 2005.

29 Trypuc et al., 2006.

30 This shift to volume-based funding is controversial because measures for appropriateness and quality are not yet in place. See Brian Day in Appendix.

31 Canadian Association of Emergency Physicians, 2007.

32 Bagust et al., 2005.

33 Canadian Institute for Health Information, 2005b.

34 British Medical Association, 2002.

35 Cohen et al., 2005.

36 Canadian Institute for Health Information, 2007.

37 *Globe and Mail*, 2007.

38 Brian Day, "Guest Column: Patient Focused Funding", *Sounding Board*, Vancouver Board of Trade, January 2007, Vol. 47, No. 1. This column is a summary of Brian Day's presentation at the BC government's opening conference for the BC Conversation on Health, October 10, 2006; Camille Bains, "Funding hospitals by patient count, CMA prescribe", *Globe and Mail*, January 24, 2007; Gary Mason, "BC is refreshingly candid on private sector health care", *Globe and Mail*, March 6, 2007, A7.

39 "NHS hospitals can use celebrities to advertise – but there is a question over payment", *Guardian*, November 28, 2006.

40 Day, Op cit.

41 R. Rogers et al. "'HRG drift' and payment by results", *British Medical Journal*, March 12, 2005, 330:563.

42 G. Marini and Andrew Street, "A transaction costs analysis of changing contractual relations in the English NHS", *Health Policy*, 2006.11.007.

43 House of Commons Health Committee, *Independent Sector Treatment Centre, Fourth Report Session 2005*-06, Volume 1, pp. 37-38.

44 Ibid.

45 "Doctors claim study of patient choice suppressed", *Guardian*, January 1, 2007.

46 Annabel Ferriman, "BMA condemns competition and payment by results in NHS", *British Medical Journal*, July 2005, Vol. 331, p. 9.

47 John Carvel, "Health guru urges change of tack on funding to save NHS", *The Guardian*, February 26, 2007.

48 Ibid.

49 Audit Commission, *Early Lessons from Payment By Results,* October 2005, pp. 4-5.

50 UNISON, *In the Interests of Patients? The impact of the creation of a commercial market in the provision of NHS Care*, January 2007, pp. 9-10.

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