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### REPORT ON THE WAITING TIME PANEL MEETING

The initial meeting of the WCWL Waiting Time Panel was held in Calgary on 20 & 21 August. All but one of the members, representing provider and public perspectives, were able to attend. We were gratified by such a high turn-out in the middle of summer vacation season.

The session began on Wednesday with panelists and WCWL associates getting together for a reception and dinner. Our after-dinner speaker was Duncan Fisher, the Assistant Deputy Minister, Saskatchewan Health. Duncan described the Saskatchewan Surgical Care Network and several of their initiatives: the standardized patient assessment process; evaluation in association with WCWL; the web-based registry; and target wait times.

The Panel meeting itself got underway the following morning. Three objectives for the session were set: first, to brief panel members on WCWL activities to date, and set the scene for the waiting time project; second, to establish a work plan and agree on the major deliverables; third, to discuss how we will move from "inputs" to draft waiting times. Each of these inputs was described in turn; a patient survey, a contingent valuation exercise, and consultation with clinical experts. To date we have completed the literature review and abstracted information on waiting times from earlier WCWL work.

Did we meet the objectives? On balance, we did but the third objective - the methodology behind the synthesis of evidence into wait times - will present many challenges as we move forward. Nevertheless, at the end of the meeting all parties endorsed moving forward with the data collection in anticipation of a second meeting in the late fall.

*John McGurran, WCWL Project Director*

### NEW WCWL ASSOCIATES

**Carolyn De Coster will be joining WCWL for a one-year term beginning October 1, 2003.** Carolyn began her career in nursing at St. Boniface General Hospital as a paediatric nurse. In 1987, she left St. Boniface to attend the MBA program at the University of Manitoba, after which she worked as a research analyst with Manitoba Health Organizations. Since 1991, she has worked at the Manitoba Centre for Health Policy at the University of Manitoba, where she is a Senior Researcher and Communications Co-ordinator, and an Assistant Professor in the Department of Community Health Sciences. Her PhD, completed in June 2002, focused on waiting times for cataract surgery.

Carolyn has been involved with WCWL from the first conceptual meeting held in Regina in May 1998. She was on the panel that developed the General Surgery priority tool in the first phase of the project, and currently sits on both the Research and Steering Committees, as well as the Winnipeg RHA WCWL Implementation and Evaluation Steering Committee. During her stay in Calgary, she will focus on modification of existing tools for use by general and family practitioners. She is also interested in exploring the influence of physician characteristics on waiting times.

**Ms. Catherine Hutt, an NHS Management Trainee, will be joining WCWL for a 3 month term beginning September 15, 2003.** Following is a note of introduction from Catherine.

As summer draws to a close in England, I'm starting to think about the warm clothes I need to pack for my three-month trip to Calgary. I work for the UK National Health Service (NHS) as a Management Trainee and a year into the job I'm about to undertake a placement abroad. I'm thrilled to be spending this with Calgary Health Region and the Western Canada Waiting List Project.

I know I'll gain a lot from the trip. I'm delighted to be working on a project of such importance. Waiting lists are a big problem in the UK, particularly in orthopaedics, and I look forward to applying my knowledge when I return to England. I look forward to learning about Canadian culture and the Canadian health system and I hope to learn to ski as well!

## OECD WAITING TIMES PROJECT FOR ELECTIVE SURGERY

Waiting times for elective surgery are a main health policy concern in approximately half of OECD countries. Mean waiting times are above three months in several countries and maximum waiting times can stretch into years. They generate dissatisfaction for the patients and among the general public.

This project investigates the causes of variations in waiting times across OECD countries and compares the effectiveness of policies for tackling excessive waiting times. The Working Paper, **Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries (OECD Health Working Paper N°6)**, was published in July 2003 (<http://www.oecd.org/health>). Stage 2 of the project will present comparable measures of mean and median waiting times for selected surgical procedures (like hip replacement and cataract surgery), and investigate potential explanations for the reported variations.

It is argued that both optimum rates of surgery and optimum waiting times will differ across countries. Waiting times tend to be formed in countries which combine public health insurance (with zero or low cost sharing) and constraints on surgical capacity. Public health insurance removes from patients the financial barriers to access, leading to high potential demand. Constraints on capacity - desirable to achieve optimum surgery rates - prevent supply from matching this demand. Under such circumstances non-price rationing in the form of waiting lists takes over from price rationing as a means of equilibrating supply and demand. Optimum waiting times will not be zero. It can be cost-effective to maintain short queues of elective patients for two reasons: 1) the adverse health consequences of short delays are small, and 2) there are savings in hospital capacity from allowing queues to form.

It is argued that, in principle, waiting times can be reduced through supply-side policies (if the volume of surgery is not considered adequate) or through demand-side policies (if the volume of surgery is considered to be adequate). Supply-side policies include raising public capacity by increasing the number of specialists and beds, or by using the available capacity in the private sector. Demand-side policies include the prioritization of patients according to need and managing access to waiting lists accordingly. Alternatively, they may involve encouraging private health insurance coverage, with the aim of diverting demand from public care to private care.

A number of provisional results are identified in the review of the policies. On the supply side, an example would be the pronounced reductions in waiting times for coronary revascularisation surgery in Denmark, which have been brought about by significant increases in capacity. However, a common experience is to take measures aimed at reducing waiting times by increasing capacity, only to find that after a brief period demand has increased and waiting times have reverted to levels similar to those before the introduction of the measures. Such responses may be hard to overcome, since demand responds

positively to reductions in waiting times. Moreover, demand is also rising because of technological changes.

New Zealand's dramatic reductions in waiting times longer than six months have, by contrast, been mainly the result of demand management, using clinical guidelines to prioritize patients. Australia has successfully reduced waiting times for elective surgeries by using tax incentives and private health insurance. However, it is too early to judge the long-term success of these policies.

Several countries have found that the application of 'maximum waiting-times guarantees' has conflicted with clinical prioritization. Attempts to avoid the clinical prioritization issue, by offering guarantees to patients conditional on high need, have been tried and abandoned in Norway and Sweden.

It is important to add that the different policies mentioned above will have had different implications for the benefits and costs of health care. For example, demand management is an inexpensive way of controlling waiting times but is unlikely to improve health (unless surgery is unnecessary). Increasing surgical capacity and activity is a more costly way of bringing down waiting times but it can bring improvements in health.

*Submitted by Dr. Luigi Siciliani, OECD Health Policy Unit Administrator and Mr. Jeremy Hurst, OECD Health Policy Unit Principal Administrator*

## WCWL PUBLICATION UPDATE

Dennis Pitt, Tom Noseworthy, Jacques Guilbert and John Williams. **Waiting Lists: Management, Legalities and Ethics.** Canadian Journal of Surgery. June 2003. 46(3). 170-175.

Gordon Arnett, David Hadorn, and the Steering Committee of the Western Canada Waiting List Project. **Developing Priority Criteria for Hip and Knee Replacement: Results from the Western Canada Waiting List Project.** Canadian Journal of Surgery. August 2003. 46(4). 290-296.

## UPCOMING MEETINGS

**October 2003** - WCWL Steering Committee teleconference

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## UPDATE

**THE UPDATE** is the monthly newsletter of the Western Canada Waiting List Project. It is published at the Department of Community Health Sciences, University of Calgary, 3330 Hospital Drive NW, Calgary, Alberta, Canada T2N 4N1. For more information, please contact John McGurran, Project Director, at 403-210-3813 [info@wcwl.org](mailto:info@wcwl.org) or visit our website at <http://www.wcwl.org>

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