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## Director's Note

This issue of THE UPDATE features a series of Questions and Answers about the project, developed by WCWL Research Director Dr. David Hadorn [hadorn@dnai.com](mailto:hadorn@dnai.com).

The Q & A addresses both general and specific issues raised by this undertaking. A series of detailed background papers is being developed for publication and will appear on our website <http://www.wcwl.org> in due course.

Next steps for the project over the summer include the completion of the background research and literature review for the panels and the organization of the first meetings of all panels in Calgary in mid-October. Panel membership recruitment is now complete and more than 50 clinicians from the western provinces are involved in this undertaking

Again, your feedback on this newsletter is welcomed, encouraged in fact. Look for an update on our work-plan in the August issue.

Have a great summer!

*John J McGurran, Project Director*

## WCWL Q & A

*By Dr. David Hadorn*

### *What's this project all about?*

In 1998, a major study sponsored by Health Canada concluded, among other things, that "there is widespread interest in standardizing data and coordinating and integrating waiting lists" and that significant investment is needed in "waiting list infrastructure." The Western Canada Waiting List Project will begin this work.

### *What problem is this project supposed to address?*

There are three major concerns about waiting lists in Canada. The first is that the waiting lists aren't fair—by the luck of the draw or because of inadequate management, some people or groups are better served than others.

The second is that some people end up waiting so long that their health status or ability to benefit from service is diminished. Thirdly, there is concern that standardized and transparent methods do not exist for collecting and comparing information about the clinical status of patients on waiting lists—including the extent of any suffering, disability, and premature mortality they may be experiencing. Nor is much known about how doctors take into account the expected outcomes of services in determining relative priority.

### *Why is this project necessary?*

There are currently no mechanisms built into our health care system to address these problems. In recent years, calls have increased for assessment and accountability of health care. Measures and tools such as those to be developed in this project will go some way toward showing progress in addressing political and public demands for accountability and transparency in how waiting lists are managed.

### *What is the major goal of this project?*

The project's major objective is to improve the fairness of the system. We propose to do this by developing valid and reliable clinical measures of patients' relative priority for wait-listed services. These measures will reflect the severity of patients' clinical conditions, including the extent of pain, reduction of function, threat of premature mortality, and potential to benefit from the service or procedure in question. Using these measures, it will be possible to assess and compare the clinical panels and expected outcomes of patients within and across waiting lists.

The measures will be developed by panels of clinical experts, based on evidence of service effectiveness and clinical need.

### *What clinical areas are being looked at?*

The five clinical areas chosen for this project incorporate a broad range of diagnostic and therapeutic procedures and one where the main issue is access to consultation. They are: MRI scanning; hip and knee replacement; cataract surgery; all general surgery procedures; and children's mental health. In addition, we will endeavor to develop generic measures that will permit comparison of urgency, benefit, and relative priority across these five clinical areas.

### *Who will do this work?*

The design, development, and evaluation of these tools will be performed primarily by five multidisciplinary clinical panels—one for each of the areas under study. Literature reviews will be conducted by project staff working with the panels. Technical, research, and administrative support will be available to each panel in accordance with the project budget. Dr. David Hadorn, a physician and researcher with considerable experience in waiting list management and priority criteria, will co-chair each panel.

### *Why not use an “urgent/semi-urgent/elective” framework to set priorities?*

Although useful as a “rough and ready” guide to priority, the standard three-level framework is too broad, vague, and subjective to provide a reliable basis for assessing and comparing case-mix within and across waiting lists. Experience has shown that the terms “urgent” etc. are used inconsistently, so that similar patients presenting in different settings may be assigned to different categories. A greater degree of transparency and consistency in how clinical factors are tied to priority is needed to gain confidence in the validity of priority assessments.

### *What about the system developed in Ontario for coronary artery bypass surgery?*

The priority system used in Ontario for coronary artery bypass graft surgery (CABG) has much to recommend it. Indeed, it is one of the few functioning prioritization systems in the world. However, it was developed based on the specifying and rating of hundreds of detailed clinical indications (e.g. “double vessel disease with left anterior descending artery involvement, mildly positive exercise stress test, markedly reduced ventricular function, and Class III angina”). In Ontario this process was aided by the presence of existing CABG indications previously developed in collaboration with RAND in California. Such indications are not available for the clinical areas included in this study, and

more generally would not be available for other clinical situations for which waiting lists exist. Furthermore, the complexity of such a system reduces the likelihood that it will be embraced and widely used on an everyday basis to manage waiting lists in other clinical areas.

Also, CABG is one of a rather small set of procedures where the stakes are particularly high: waiting too long could lead to death. Because of this, it is worth investing in very precise measurement and patient assessment. In most other areas, a simpler but still valid system is likely to serve both patients and physicians quite well.

### *What sort of simpler system?*

One useful approach assigns points to various clinical findings (e.g. degree of pain or functional impairment). These points are then weighted and summed in order to develop a scoring system reflective of relative priority. This was (and continues to be) the approach used in New Zealand for managing waiting lists.

Point-count-based priority measures are similar to statistical models used throughout medicine. Perhaps the best-known example of a clinical point-count system is the Apgar Score, which is widely used in neonatal assessment. The Apgar Score incorporates five clinical factors (viz., heart rate, respiratory effort, color, muscle tone, responsiveness to stimuli). Each factor consists of three levels (e.g. good, fair, poor), which are weighted (0, 1, or 2 points) to permit a total score to be calculated for each patient. In this case, higher scores indicate better prognoses.

Another example is the APACHE scoring system, which is routinely used as an index of clinical severity, as well as for research purposes to estimate mortality risk. “Mortality prediction models” of this kind incorporate relevant clinical variables (e.g. blood pressure, serum electrolytes) into an additive, point-count formula. Scores are calculated for each individual patient, with higher scores (generally) reflecting greater mortality risk.

A large number of similar measures have been developed for use in diagnosing the presence of a broad range of conditions, including appendicitis and myocardial infarction.

Priority measures estimate the degree of clinical severity and the likely benefit to be obtained from treatment. Patients with higher degrees of severity and expected benefit will be deemed higher priority.

*If this project succeeds, what will we be able to do that we cannot do now?*

Firstly, we will be able to evaluate and improve the fairness of current approaches through which patients get prioritized. Secondly, we will be able to provide tools that, when implemented more widely, should improve patient health status, quality of life, and functional capacity. Thirdly, we will have tools that can be used to assess and compare the performance of waiting list systems across clinical areas and jurisdictions. Fourthly, the tools produced by the project will be able to assist decision-makers to make effective resource allocation decisions.

Developing and implementing standardized criteria concerning the clinical status of wait-listed patients will permit, for the first time, a determination of whether and to what extent patients with similar conditions (including similar expectations of benefit) receive access to services in comparable time-frames across waiting lists and geographical areas. In addition, a valid basis will exist for determining and comparing the level of services being provided around the country, in terms of the kinds of patients receiving (or not receiving) services. Specifically, it will be possible to assess whether patients of a given severity or priority are receiving services in one location but not in another. In addition, in New Zealand it was possible in many cases to specify a “clinically desirable” threshold above which patients should receive wait-listed treatments.

*Why should physicians want to participate in this project?*

There are several good reasons why physicians should support this project—as most did in New Zealand. Firstly, being able to measure the severity of condition and capacity to benefit of wait-listed patients will improve fairness in access to services for patients. Secondly, the use of transparent, consistent, evidence-based criteria as aids to (rather than substitutes for) decision-making can greatly improve the scientific basis of medical practice—including the reliability and consistency of priority judgements. Thirdly, the availability of such criteria will improve fairness in access to scarce resources such as operating room time for physicians, and will also make it much easier for them to meet concerns about quality and accountability. Fourthly, the kinds of clinical criteria envisioned here can provide powerful information to guide the allocation of financial and human resources for specific services.

*Are there any risks in making prioritization decisions explicit?*

Potential problems inherent in making priority decisions explicit include:

- the potentially negative effects of formally “grading” patients as being “low priority”;
- the pressures that may be exerted by explicit information with respect to the system’s capabilities (whether to increase or decrease resources in specific areas);
- the potential for “gaming” the system, i.e., using knowledge of the criteria used to rank patients to one’s own (or one’s patients’) advantage.

*Where can I get more information on the project and the issues described above?*

Several of the issues discussed above are described in more detail in a series of project background papers. These are:

1. Defining our terms
2. Priority criteria: conceptual and technical issues
3. Explicitness in setting healthcare priorities
4. Evidence of effectiveness

These papers are available upon request.

Another source of information is the project’s website: <http://www.wcwl.org> which is currently under development.

*Where is the project situated?*

The Western Canada Waiting List Project (WCWL) is funded by Health Canada’s Health Transition Fund initiative until the fall of 2000. The administrative office is within the Department of Public Health Sciences at the University of Alberta. Dr. Tom Noseworthy serves as the project Chair.

The design, development and evaluation aspects of the project will take place primarily within five multidisciplinary clinical panels—one for each of the areas of interest. Each panel will be hosted by a Regional Health Authority (RHA) and will consist of 12 members, predominantly physicians. The panels will be co-chaired by Dr. David Hadorn and a clinical leader nominated by the host RHA.

*Who are the key contacts?*

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## UPDATE

### WESTERN CANADA WAITING LIST PROJECT

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