WCWL
Western Canada Waiting List Project

UPDATE
WCWL Newsletter

May, June, July 2001

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What's New?

- Following the public release of the final report in May, project activities have focused for the most part on dissemination of our findings and recommendations, and on development of a work plan for the next steps.

- Dr. Tom Noseworthy has been appointed Professor of Health Policy and Management in the Department of Community Health Sciences at the University of Calgary, and can be reached by telephone at 403-220-2481 or by e-mail at tnosewor@ucalgary.ca.

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Dissemination, Uptake, and WCWL–2

Consistent with the expectations that have been articulated since the work began, interest in the project and the priority criteria remains high. Among the more frequently asked questions is "when are the tools going to be used?"

Since its May 1 public release, over 700 copies of the final report have been distributed worldwide. The findings, recommendations, and lessons learned were presented at Health Transition Fund "Sharing the Learning" Workshops in Winnipeg (May 7), Vancouver (May 28), and Moncton (June 18). These initiatives, coupled with presentations to meetings of the Canadian College of Health Service Executives (in Yellowknife, Edmonton, and Saskatoon), the Canadian Healthcare Association, medical associations, and senior health ministry personnel, have provided many opportunities to communicate our findings to healthcare stakeholders and decision-makers.

Academic health researchers and practising physicians comprise another key audience; primary dissemination to that group will occur through publication in peer-reviewed clinical literature. Manuscripts have been submitted for publication to clinical specialty journals, one in each of the five areas for which a tool was developed. Five additional papers are in progress: on the rationale, methods, and policy implications; on standardization of the definition of waiting time; on approaches to establishing benchmarks for waiting times; on waiting lists from a distributive justice perspective; and on the views of the public and health authorities on the WCWL approach to prioritization.

Together with frequent attention from the news media, explicit endorsement from the public opinion focus sessions, and cautiously optimistic support from the health authorities we surveyed, it would appear that there is a clear pathway for implemention of these tools, ideally in an evaluative framework.

It has been pointed out before and bears repeating that the path from research to implementation is not well understood, despite the evidence of an extensive literature on the subtleties of the process. The transfer and uptake of research findings to practice is complex, time-consuming, and laborious.1 While most of this literature deals with clinical interventions and the relevant evidence consists of controlled clinical studies, perhaps there are lessons for WCWL. (A future issue of the UPDATE will deal with uptake of healthcare management issues.)

As a starting point, implementation ought to be supported where there is good evidence for effectiveness; conversely, uptake of ineffective innovation ought to be actively prevented.2 In the middle ground, and in the absence of good evidence, implementation should be delayed while the necessary detail is being sought.

Rubin et al introduce four elements of research transfer: good information on the effectiveness and utility of an intervention; good access to this information for the people who might (ought to) use it; environment supportive of innovation and behaviour change; the use of evidence-based promotion strategies.3

In the absence of a commonly accepted "good information" standard for the development of priority criteria tools, it is the consensus of the WCWL Partnership and observers that the evidence is "good enough" to support introduction. As recommended in the WCWL final report, implementation should proceed in conjunction with careful monitoring and evaluation. This should include measures of the validity and reliability of the tools, their utility in a patient care setting, their acceptability to the public and providers, and insight into how the tools might be applied across procedures. Furthermore, the evaluated implementation ground ought to include a range of health authorities, including rural and remote ones where the relevant service is offered.

To the extent that this evaluative work can be more proficiently carried out under the auspices of a partnership, and recognizing the opportunities for economies of scale and greater generalizability, a proposal is being developed for a second phase WCWL_2 which will support and evaluate implementation in real world healthcare settings. Evidence from New Zealand suggests that inclusion of all key stakeholders, a commitment to transparency, and adoption of rigorous methodology will promote the uptake and use of prioritization tools and greater accountability in the public system.4

The path from research to implementation may be arduous, but in the interest of promoting fairness and equity of access it is one worth following.with key clinical and administrative informants.

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[1] Lomas J. Improving Research Dissemination and Uptake in the Health Sector: Beyond the Sound of One Hand Clapping. McMaster University Centre for Health Economics and Policy Analysis, Policy Commentary C97-1, Nov 1997

[2] Haines A, Jones R. Implementing findings of research. BMJ 1994; 308 (6942): 1488-92

[3] Rubin GL et al. Disseminating and Implementing the Evidence. Evidence-based Health Advice Workshop. Nov 4-5, 1998

[4] Gauld R, Derrett S. Solving the surgical waiting list problem? New Zealand's "booking system." Int J Health Plann Mgmt 2000; 15: 259-72

New Zealand Report

New Zealand has had considerable experience with the use of point-count prioritization tools governing access to elective services in a public healthcare system. Notwithstanding the significant healthcare (coexistence of public and private delivery systems) and political (absence of provincial governments) differences, many valuable lessons for Canada can be learned from their experience.

Initiated as a matter of national policy under the auspices of a National Advisory Committee on Core Health and Disability Services,1 implementation has progressed steadily since the early 1990s. Toward the end of the decade, evidence of the movement of funding to address variation in access, improvements to scheduling, and better liaison between primary and secondary care were identified as successes, as was its acceptance by patients.2

Initially, criteria were developed in five high-volume and high-cost areas (cataract surgery, hip and knee joint replacement, coronary artery bypass graft and angioplasty, cholecystectomy, and tubes for otitis media with effusion). By March 2001, progress had been made, including implementation in many instances, with the development of national referral and assessment criteria in 30 diverse clinical areas.3 Many of these are available on a government website at:www.nzgg.org.nz/moh-esg/

National-level reform of this scope cannot move forward without controversy and debate. For example, it has been acknowledged that specialty-specific tools, while useful and beneficial to patients requiring that service, are incommensurate and not useful for resource allocation across clinical domains.4 Furthermore, the development and uptake of the criteria has not been guided by a national strategy nor accompanied by a national evaluation.

To remedy that latter situation, a consortium of prominent surgeons and researchers with support from the Ministry of Health will conduct an independent and comprehensive three-year evaluation of the performance and impact of the clinical priority assessment criteria.5 The research agenda includes: an environmental scan of the development and performance of the criteria; reliability studies for selected criteria; a patient-outcome evaluation of the CABG criteria; and an assessment of the impact of prioritization based on the criteria vs. other methods and systems.6

Gauld and Derrett,7 perhaps seeing the proverbial glass as being half empty, describe the transition from waiting lists to an urgency-scored booking system as being less than satisfactory. By way of advice to other jurisdictions, they identify three key factors instrumental to the success of a

venture of this magnitude: achieve nation-wide consistency in criteria and thresholds for service; develop a system that is rational and transparent; and undertake rigorous pilot testing of the criteria and the systems for booking people.

Regular updates of the New Zealand evaluation will be provided here.

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[1] Hadorn DC, Holmes AC. The New Zealand priority criteria project: Part 1: Over view. BMJ 1997; 314 (7074): 131-4

[2] Hefford B, Holmes A. Booking systems for elective services: the New Zealand experience. Aust Health Rev 1999; 22 (4): 61-73

[3] Elective Services Update. March 2001

[4] Hindle D, Commentary (on Hefford and Holmes, op cit) Aust Health Rev 1999; 22 (4): 74-9

[5] Elective Services Update. July 2001

[6] Kirk R. Personal communication. June 2001

Update from Ontario

Progress on the Ontario Wait List (OWL) Project, originally described in an earlier issue of the UPDATE, has been steady, according to co-principal investigator Caroline Rafferty, and is on schedule for completion in the fall of this year.

Both the MRI and the cataract surgery panels recommended revisions to the WCWL tool they used as a starting point and are currently involved in a second round of reliability testing using standardized cases.

The general surgery panel retained the WCWL priority rating criteria and modified the tool to capture physician and patient perceptions of urgency as well as measuring actual waiting time. The study will also provide data that could be used to further evaluate the WCWL physician priority rating criteria.

In addition to receiving the work of the clinical panels, the OWL Steering Committee is working towards recommendations for the future development of urgency rating tools and for the components of a system-wide waiting list management system.

To learn more about OWL, please contact Caroline Rafferty of the Ontario Joint Policy and Planning Committee by e-mail at crafferty@jppc.org or by telephone at 416-599-5772 ext 223.

McGill Institute Conference

The year 2002 marks the thirtieth anniversary of the full realization of publicly-funded health care in Canada. Newly-appointed McGill Institute for the Study of Canada (MISC) Director, Antonia Maioni, sees this as an opportunity to revisit both principles and practices in an attempt to diagnose the real problems and discuss the real issues surrounding the future of Canada's health care system. The February 2002 MISC conference will serve as a public forum for substantive debate about the problems and solutions facing specialists and citizens alike. Contact Lynne Darroch by telephone at 514-398-2658 or by e-mail at ldarroch@leacock.lan.mcgill.ca or visit the MISC website at www.arts.mcgill.ca/programs/misc.

Upcoming Events

- Sep 22-25, 2001 — 4th International Conference on the Scientific Basis of Health Services, Sydney, Australia
  http://www.icsbhs.org
- Oct 2-5, 2001 — International Society for Quality in Health Care (ISQua) 2001 Conference, Buenos Aires, Argentina
  http://www.isqua.org.au/isquaPages/Conferences.html
- Feb 15-16, 2002 — Diagnostics and Solutions: Is the Canadian Model of Health Care Sustainable? The 7th Annual Conference of the McGill Institute for the Study of Canada
  http://www.arts.mcgill.ca/programs/misc

UPDATE

WESTERN CANADA WAITING LIST PROJECT

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