

Western Canada Waiting List Project

“WCWL - Moving Forward”

Background

Growing demand and spending restraints through the 1990s left Canadians increasingly worried about access to health care; the Western Canada Waiting List Project (WCWL) was created in response to those concerns. Its mission:

To improve the fairness of the system, so that Canadians' access to appropriate and effective medical services is prioritized on the basis of need and potential to benefit.

The WCWL Partnership brought together researchers, regional health authorities, medical associations, provincial health departments and federal agencies to move forward with a participative research agenda committed to one overarching goal — the development of valid, reliable, practical and clinically transparent measures of patients' priority for wait-listed services. In WCWL 1, scoring tools for cataract surgery, general surgery, hip and knee replacement, magnetic resonance imaging (MRI) scanning and children's mental health were developed through extensive clinical and empirical input.

WCWL 2 Action Research Agenda

Building on the WCWL 1 infrastructure, input and recommendations, WCWL 2 proposed a multi-faceted research and developmental agenda, anchored in a supportive and collaborative role with the existing community of interest. Three themes formed the nucleus of WCWL 2 activities:

Implementation with Evaluation: The partnership concluded that the WCWL tools warranted implementation by health authorities for observation and evaluation. Responsibility and accountability for tool implementation was left with regional and provincial health authorities, with WCWL providing support through core resources for design, analysis and evaluation.

The approaches to implementation and evaluation of priority tools have been diverse, and have taken place in a range of settings across Western Canada. This has given WCWL 2, as a collaborative observer, a valuable opportunity to identify key process elements and share information about critical success factors and challenges to other jurisdictions proposing to integrate priority criteria tools into their waiting systems.

Formulation of Benchmark Waiting Times:

The primary purpose of the Waiting Time Project was to develop methods for formulating maximum acceptable waiting times for one or more procedures for which there exist valid tools. The project focused primarily on developing maximum acceptable waiting times for hip

and knee replacement and cataract surgery but an underlying objective of the work was to develop a methodology that could be applied to other procedures.

We used a range of inputs to formulate benchmarks for acceptable waits for care, including extensive literature reviews on the effects of waiting on patients and on outcomes of care, lessons from earlier WCWL work, and information gathered from clinical, patient and public input, linked to the urgency scoring system of WCWL priority tools. By integrating priority criteria into the methodology, this approach allowed us to take a first step toward the development of maximum acceptable waiting times related to patient urgency.

We established a Waiting Time Panel to oversee the work, synthesize the findings and formulate maximum acceptable waiting times for hip and knee replacement and cataract surgery. The Panel had representatives from health providers and the public and equal representation from the four western provinces (see Appendix C.1).

The clinical, patient and public input, linked to the Priority Criteria Scores (PCS), was our primary source of information. A range of methodologies was used to elicit approximations from these groups, including direct methods for clinicians and patients and an indirect method for the public (see Section 3.3 for more details). To obtain clinical input, we asked ophthalmologists and orthopedic surgeons to review standardized patient cases, developed using the priority criteria, to provide for each case a maximum acceptable waiting time. To obtain patient input, patients scored using the priority criteria were asked to provide a maximum acceptable waiting time for a case such as theirs. To obtain public input, a discrete choice experiment was conducted in which participants choose among scenarios with different levels of a set of attributes taken from the priority criteria. This indirect methodology used was deemed most appropriate given that members of the general public have neither the medical expertise nor the experience of waiting for joint replacement or cataract removal to provide a direct estimation.

The three inputs are as follows:

	Clinical	Patient	Public
Hip and Knee Replacement			
Urgency I (Least urgent)	26 weeks	12 weeks	147 weeks
Urgency II	13 weeks	8 weeks	87 weeks
Urgency III (Most urgent)	4 weeks	4 weeks	28 weeks
Cataract Surgery			
Urgency I (Least urgent)	17 weeks	8 weeks	142 weeks
Urgency II	9 weeks	4 weeks	122 weeks
Urgency III (Most urgent)	4 weeks	4 weeks	52 weeks

The resulting maximum acceptable waiting times varied across the three groups. As expected, for all three groups, the shortest waits were associated with the highest level of urgency. There was a higher level of agreement among the clinicians, patients and the public for the most urgent cases and less agreement for the least urgent cases. Overall, patients and physicians were more in agreement with each other than with the public. This may reflect a higher tolerance for waiting by the general public, or could be related to the different methodologies we used.

All inputs were considered and synthesized by the Waiting Time Panel. Maximum acceptable waiting times were developed for three clinically relevant levels of urgency. The proposed maximum acceptable waiting time estimates for hip and knee replacement and cataract surgery are as follows:

	Hip/Knee Replacement	Cataract Surgery
Urgency I	20 weeks	12 weeks
Urgency II	12 weeks	8 weeks
Urgency III	4 weeks	4 weeks

These should be viewed as a first step toward the development of benchmark waits; they have not been tested in real-world settings. Our method did not take into account real-world considerations such as the supply of physicians and nurses or resources required to implement these standards. Furthermore, these waiting times may change with future refinements to the methodology and inclusion of new evidence, such as the impact of waiting on health and medical outcomes.

Finally, it should also be recognized that implementation of any standards for acceptable waits for care would logically include the adoption of standards for patient prioritization and appropriateness of care. The management of surgical care takes place at the local level and rests with hospitals and health authorities that must meet the needs of all surgical care patients. The wait times in this report focus on two procedures and were not developed in the context of balancing delivery of other competing health care priorities.

Adaptations of Tools for Primary Health Care: Another task was to “develop point-count systems to prioritize referrals to specialists from primary care physicians or other specialists.” The objective was to create user-friendly, clinically coherent scoring systems that specialists could use to judge the urgency of referrals from primary-care physicians, based on modification of the original WCWL Priority Criteria Scores (PCS). We focused on hip and knee replacement and children’s mental health and created the Primary Care Panel to oversee the work, including determining necessary modifications, developing revised item weights and conducting reliability tests of the revised Priority Referral Scores (PRS).

The hip and knee replacement tool was expanded from the original version by adding two non-surgical patient management items: walking supports and use of pharmaceuticals. The tool had very good inter-and intra-rater reliability. We adapted the children's mental health tool by reducing the number of criteria to eight and re-calculating their weights. Reliability testing of this tool will need to be conducted in the future.

Sustain the WCWL Role: In support of our three major themes — implementation with evaluation, formulation of benchmark waiting times and adaptation of tools for primary health care — discussed above, WCWL 2 continued to develop WCWL as a community of interest, supporting partners through core and shared resources and acting as a clearinghouse for information exchange and linkages.

Conclusions

WCWL 2 represents the collaborative input and activities of stakeholders with different perspectives, willing to work together on access to services and management of waiting times in Canada. WCWL 2 built on the existing infrastructure and community of interest by promoting the implementation and evaluation of its tools by health authorities, developing a methodology for formulating maximum acceptable waiting times and adapting the tools for use in primary care referrals.

This report represents the culmination of more than 6 years of work by the now 22 partner organizations, through two phases of activity. The project has made progress on the development of valid, reliable, practical and clinically transparent measures for prioritizing patients waiting for selected medical services, and made inroads into suggesting acceptable waiting times for some procedures, linked to priority status. Logical next steps would now include measuring and monitoring clinical outcomes in the context of the priority scoring tools and suggested maximal waiting times.

The full text of this report and its appendices is available on the project website www.wcwl.ca