Review of Ontario’s Wait Time Information System

by

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A Report Commissioned by the Ontario Ministry of Health and Long Term Care

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1. Mandate

Following the release of the Auditor General’s report that looked at the management and use of diagnostic equipment in Ontario’s hospitals, the Government of Ontario requested that, with respect to the gathering and reporting of data on wait times, I:

- Review the Auditor General’s concerns and the government’s progress made to date to further improve upon the work already underway
- Review the existing methodology of how wait times are calculated and reported on the government’s public website www.ontariowaittimes.com
- Provide additional recommendations that would further enhance public confidence in the accuracy and usability of information provided on the public website.

2. Overview

The goal of Ontario's Wait Time Strategy, announced by the Minister of Health and Long Term Care on November 17, 2004, is to improve access to health care services by reducing the time that adult Ontarians wait for services in five areas: cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements, and MRI/CT scans.

In the context of this strategy, the purpose of the Wait Time Information System (WTIS) is to assist in the management of waitlists and the measurement of wait times in Ontario. The timing of waits in Ontario begins with the ‘Decision to Treat Date’ (Surgery) or the ‘Order Received Date’ (MRI/CT Scans) and ends with a ‘Procedure Date’ or a ‘Report Verified Date.’

Thus, for surgical procedures, Ontario measures the wait time from when a patient and surgeon decide to proceed with surgery until the actual procedure is completed. For diagnostic scans (MRI and CT), Ontario measures the wait time from when a diagnostic
scan order is received by the hospital until the actual exam is completed. This interval is typically referred to as from ‘decision to treat’ to ‘treatment.’

The time a patient spends waiting in between obtaining a referral to a specialist from a primary care provider, seeing the specialist and making the decision to proceed with treatment is not measured by the current system.

A Wait Time Information Office (WTIO) has been established to receive, analyze and report on wait time data from all hospitals that receive wait time funding. This funding is over and above the annual budget that the hospital receives from the Ministry of Health and Long Term care. It is funding that is dedicated to wait times reduction and designed to increase the number of procedures performed. To date, the Government of Ontario has invested $614 million in its wait time strategy.

The WTIS has begun to track patients waiting for a specific procedure based on a priority level that defines the maximum time each patient should have to wait. The priority level is based on an assessment of how urgently a patient requires treatment based on his or her medical condition. These target wait times vary according to the procedure involved, as indicated in the table below.

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<tr>
<th>Procedure</th>
<th>Priority I</th>
<th>Priority II</th>
<th>Priority III</th>
<th>Priority IV</th>
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<tbody>
<tr>
<td>Cataract Surgery</td>
<td>Immediate</td>
<td>6 weeks</td>
<td>12 weeks</td>
<td>26 weeks</td>
</tr>
<tr>
<td>Hip/Knee Replacement Surgery</td>
<td>Immediate</td>
<td>6 weeks</td>
<td>12 weeks</td>
<td>26 weeks</td>
</tr>
<tr>
<td>Cardiac Bypass Surgery</td>
<td>Immediate</td>
<td>2 weeks</td>
<td>6 weeks</td>
<td>26 weeks</td>
</tr>
<tr>
<td>MRI/CT Scans</td>
<td>Immediate</td>
<td>48 hours</td>
<td>2–10 days</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Cancer Surgery</td>
<td>Immediate</td>
<td>2 weeks</td>
<td>4 weeks</td>
<td>12 weeks</td>
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The WTIS is designed to enable hospital administration staff to determine how many patients are waiting, how long they have been waiting compared to access targets listed above and to monitor demand for operating room and diagnostic imaging resources. Surgeons and their staff can also use this information to help manage their waitlists and

Improving the quantity and the quality of the information on wait times is clearly a critical component to reducing wait times and enhancing the overall efficiency of the delivery of health care services. Prior to the establishment of the WTIS in Ontario in 2004, surgeons managed their own patients’ queues in their offices and referrals to surgeons were largely based on relationships between family practitioners and specialists. Consequently, hospitals had no way of knowing what the access picture was actually like, and the government could not address access issues using reliable information, since this information did not exist in Ontario or elsewhere in Canada. As a result, it was impossible for patients to hold either government or the health care system accountable on the issue that matters most to them – timely access to service.

However, the situation has substantially improved since 2004. For example, in a report done in April 2005 by the Institute for Clinical Evaluation Sciences (ICES), the estimates of wait times relied on two year old surgical data. By October 2005, the wait time data that was reported on the Ontario government website was 2 only months old (rather than 2 years old). Upon full implementation of the WTIS, it is expected that wait time data will be collected within two days and will be reported publicly shortly thereafter.

3. The Canadian Context

Efforts to reduce wait times are underway across the country. It is not always possible to make direct comparisons between provinces because of the different ways in which information is collected and reported.

However, a 2006 report by the Canadian Institute for Health Information (CIHI) indicates that all provinces have created public Web sites or reports that list wait times in one or
more of the five priority areas established by the First Ministers (cancer, heart, diagnostic imaging, joint replacement and sight restoration) and sometimes beyond. The scope of these reports varies widely, and they draw on a range of sources.

Overall, the work being done in Ontario is of a comparable standard to that being done elsewhere in the country, and in some respects Ontario is setting the standard. For example, amongst the five provinces that currently report publicly on wait times for MRI/CT scans, Ontario is the only one to include data on average, mean and 90th percentile wait times.

The table below compares the reporting of MRI and CT scans in all provinces except Quebec and Newfoundland.

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<tbody>
<tr>
<td>measure</td>
<td>Median</td>
<td>Mean, Mean, 90th percentile by region</td>
<td>Median, Mean, 90th percentile by region</td>
<td>Median by region</td>
<td>Median by specialty</td>
<td>Median</td>
<td>% of people served by region</td>
<td></td>
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<tr>
<td>Emergency cases excluded</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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As of December 2005, besides Ontario, only Nova Scotia and Alberta were reporting data for all of the other four priority procedures. Of course, much remains to be done and there are areas where Ontario lags behind some other provinces, such as in reporting wait times for all categories of surgery.

In his report tabled on December 5, 2006, the Auditor General (AG) of Ontario raised a number of concerns with respect to the collection and dissemination of information on diagnostic imaging as it is presented on the WTIS website. The AG made one specific recommendation in this area, but also identified what he regarded as additional shortcomings in the WTIS.

The AG’s recommendation (#3) is as follows:
To help hospitals better manage their MRI and CT waiting lists, and provide the public with more reliable and useful wait-time information, hospitals should:
• seek further guidance from the Ministry to clarify the starting point for the calculation of each patient’s wait time, to ensure that wait time data are being consistently reported across all hospitals; and
• measure and report wait times using the Ministry’s new Wait Time Information System, including information on patient priority levels, ability to meet benchmarks and outpatient wait times.

The other concerns expressed by the AG were that:
• The reporting of information on the Ministry’s website has some limitations.
• Inpatient and outpatient data are combined despite the fact that inpatient wait times for MRI/CT services are significantly shorter than those for outpatients.
• The website does not provide wait times for every hospital in Ontario. For example, 33 hospitals that have MRI and/or CT equipment are not included in the data since they do not receive funding under the wait time strategy and therefore are not required to report this information.
• The information reported by hospitals includes follow-up tests purposely scheduled for a future date, which makes the average time appear longer.
5. Comments on the Auditor General’s Report

The AG’s report – and particularly the oral comments made by the AG in a press conference the day his report was released to the public – raise concerns about the reliability and credibility of the data on wait times for diagnostic imaging that are currently being collected and made public on the WTIS website. While I share the AG’s concern that this data be as reliable as possible, it is essential to appreciate the challenges involved in establishing an accurate and timely data reporting system and to recognize that, although the current system is very much a work in progress, it already represents a very significant step forward from what existed prior to 2005.

The AG completed the field work for his report in the late spring of 2006, and based his report on an investigation of only three hospitals. The importance of basing data collection on clear definitions – a key point emphasized by the AG (see recommendation #3 above) – is obvious, and the Wait Times Information Office (WTIO) has been working since spring 2006 to provide those who provide data to the system with greater clarity of the definitions of what is to be measured. More importantly, as the WTIS is more fully implemented, a greater percentage of the data collected is being automatically downloaded from radiology information systems, which will help to substantially reduce any variations in data collection.

As explained in Section 2 above, data collected through the WTIS is collected by priority level. However, at the time of the AG’s report, the priority levels were relatively new and not fully implemented. In September 2006, hospitals that received funding through the wait time strategy were formally notified that the prioritization guidelines were to be implemented and all hospitals are now required to use them when booking appointments and reporting data.

Measures are also underway to address the other concerns raised by the auditor general in his report.
No system is ever perfect. But there is clear evidence that the reporting of the data on the wait times website has already improved since the AG completed the field work for his report. Moreover, the way that data is reported has been the subject of continual review as the implementation of the system proceeds. An analytic plan for the reporting strategy was developed in the spring of 2006 by the WTIO and two new working groups were formed (the Measurement and Reporting Committee and the Data Quality Working Group).

In-person interviews were conducted with a sample of patients, family members and physicians in August/September 2006 in order to gauge the usability of the wait times website. A number of recommendations came out of this survey that will make it easier for users to access the information they need. These recommendations are being implemented by the WTIO as part of its overall website strategy.

The look of the website was considerably modified in November 2006 in order to make it easier to use. Again, these changes occurred after the AG completed his field work, but prior to the release of his report.

In the course of 2007, further enhancements to the reporting on the website are expected, including more frequent reporting and two measures that will address other concerns that were raised in the AG’s report.

First, the AG was concerned that in some cases wait times were not accurately reflected because tests that had intentionally been scheduled for a later date were not being reported separately. He felt that this would give the impression that some people were waiting unnecessarily. As of the fall of 2006, however, hospitals have been required to report on procedures that are scheduled for a specified date, making it possible for the WTIS to record them separately and remove them from the overall wait time calculations.

Second, as it becomes possible to report information according to priority level, the problem of not distinguishing between in-patient and outpatient scans should be
alleviated. On the advice of its expert panel, the WTIS classifies in-patients and urgent outpatients in the second priority level.

Finally, only those hospitals that receive funding through the wait times strategy are obliged to report on wait times. At the time of the AG’s report only 59% of facilities that provide CT services were reporting wait times to the WTIO. However, by the end of April, 2007, 91% will be reporting as a condition for receiving a share of the additional CT funding that was announced by the government in September 2006.

In summary, the AG’s report was based on a small sample (3 hospitals) and looked at a system of wait times measurement that was still in a very embryonic state. An audit of any system that is undergoing substantial change will inevitably paint a picture that, while accurate, is also misleading because of the dynamic state of the system being audited.

I am therefore persuaded that measures are in place to deal with all the concerns that were raised by the AG in his report. The system that has been developed is clearly not a static one, and those responsible are acutely aware of the need to constantly improve both the accuracy of the data collected and the clarity with which it is presented to the public and professional users.

6. Collecting Wait Times Data

It was very important to begin the process of public reporting of wait time data quickly, even if the data was not ‘perfect.’ While it is imperative to strive to collect the best possible data and disseminate it in as useful a way as possible, the ‘perfect’ should not become the enemy of the ‘good.’

Some limitations to the collection of data will no doubt remain for some time to come. For example, following upon the merger of smaller hospitals across the province, there
are many hospitals that perform procedures at different sites. Wait times may vary from site to site within the same hospital, but this is not captured by the current reporting system that collects data for each hospital unit as a whole.

As I have already noted, the WTIO has been making serious efforts, and good progress, in improving the collection of data. I have confidence in the team that it is leading this effort and in the methodology that they have deployed to accomplish the objectives set out by the MOHLTC.

The WTIO has always recognized that it will take time to build a robust and credible data collection and reporting system. Moreover, the WTIO has been very careful in its public pronouncements to never make claims for its data that it cannot support.

Given the complexity of the task, I hope that commentators will resist the urge to score easy points by picking on the inevitable flaws that exist in any large, complex and evolving system, while ignoring the impressive progress that has already been made. To engage in this kind of misleading criticism will accomplish nothing other than to undermine public confidence in the WTIS.

It is equally important that those who seek to take credit for any success this wait times initiative may achieve be very careful not to make claims about the WTIS that cannot be sustained by the evidence.

7. Communicating Wait Times Information

It is essential that wait time information be communicated to the public in simple, easy to understand language. It must be clear to everyone what the wait time system allows them to do; it must be equally clear the purposes for which it cannot be used.
To this end, I believe that the focus in public reporting should be on two numbers, and these must be presented in as non-technical a fashion as possible. The first of these is the time by which one half of patients have been treated (the median) and the second is the time by which nine out of ten or 90% have been treated (90th percentile). The public reporting should not use the words ‘median’ or ‘90th percentile’ but rather use language such as ‘half the patients’ or ‘nine out of ten patients.’

Data should continue to be reported both at the regional (LHIN) level and by individual hospitals. Moreover, efforts should be made to move towards providing even more disaggregated information by reporting both on wait times at sub-units of each hospital and for each individual specialist.

I believe that efforts to make the website even more accessible to the general public, while providing data for the professional community as well, should be accelerated. Members of the public need to have easy access to what matters most to them (regional and individual hospital and specialist data). At the same time experts, providers and policy makers need the overall system performance data. These two functions must be performed in parallel and should not be presented together on the website.

There can be no infallible way of preventing the information that is communicated from being misinterpreted and used for partisan or narrow professional interests. However, by developing even further what is already a clear and transparent communications strategy, the WTIO will be able to enhance the level of public debate on the state of wait times in Ontario and what needs to be done to continue to make them shorter.

**Recommendation:** That the wait times web site focus on two numbers – the time by which one half of patients have been treated and the time by which nine out of ten have been treated.

**Recommendation:** That the wait times web site include information on wait times by individual specialist.

**Recommendation:** That the wait times web site present in parallel the information most needed by the public at large and the data required by professionals and experts, using terminology that is appropriate to each of them.
8. Building Public Confidence in the Wait Times Information System – the Need for an Independent Agency

In order to maximize public confidence in the WTIS, it is essential that an independent, arms-length agency manage the wait times information system. Not only must there not be any bureaucratic or political manipulation of the data, there must be a clear public perception that any such manipulation is not possible given the structure and functioning of the process of collecting and disseminating the wait times data.

I am not suggesting that there has been any bureaucratic or political manipulation of the data, as data is sent directly from the hospitals to the WTIO and from there it is posted directly to the website. But the public must believe that manipulation cannot happen.

Such a level of public confidence can only be sustained in the long term if the system is truly independent of government. It is in the interest of all stakeholders – including government – that this be done. Only an independent agency will be able to develop a system that will allow the public to hold government and health service providers at all levels to account.

This is a critical point: the user of the system – the public – must be able to hold the funders of the system – the provincial government – and the service providers – hospitals and doctors – to account for the timeliness and the quality of service they receive.

The task of tracking progress in reducing wait times, and driving reforms to meet wait time targets, is, as we have seen, a complex one. A number of factors inherent to this process reinforce the need to have it managed by an independent agency.

For example, such an agency is needed in order to coordinate wait time reduction efforts across the various LHINs, especially for procedures that are resource intensive, involve expensive technology and depend on the best possible input from academic health science centres. An independent agency is best placed to establish the overall direction of
wait time reduction efforts, and to set the standards and benchmarks that will enable the 14 LHINs to progress along a common path. Clearly, what is not desirable is having each of the 14 LHINs proceeding in its own direction to address the wait time problem.

The recommendation for an ongoing independent agency is a recognition of the success that Ontario has already achieved with its wait times strategy. It would be a mistake to think that there is no longer a need for an independent agency and that existing government structures could simply carry on from here. In my view, the flexibility, dynamism and technological innovation that are required can best be secured in the context of an independent agency rather than within the provincial Ministry of Health and Long Term Care.

Wait time management is here to stay – it is not a passing fad. For real reductions in wait times to continue on an ongoing basis, an independent, arms length agency must be responsible for collecting the data, monitoring progress and reporting to the public.

Recommendation: That a permanent, independent, impartial, arms length agency be established to manage the WTIS.

9. Funding Reduced Wait Times

The ongoing need to manage wait times also requires that there be a permanent, stable plan for funding all the activities necessary to reduce wait times. To date there has not been a clear statement as to whether the current program of additional funding for wait time reduction will continue.

Clearly, service providers are not going to expand capacity (e.g. hospitals are not going to build additional operating rooms) if they do not have reasonable assurance that incremental wait time funding will be available to cover the additional operating costs.
Part of the success of the wait times strategy to date has been due to making incremental, targeted funding available in exchange for precise commitments by service providers to increase the volume of the procedures they perform. The agency recommended in the previous section should be given the additional mandate, supported by the requisite funding, to enable it to intervene in the process of wait time reduction by contracting with providers for additional procedures. The independent agency should have at its disposal sufficient resources so that it can leverage strategic investments in order to stimulate the changes that are needed to reduce wait times.

This is not to say that the wait times system should immediately become the major source of funding for those providers who contract with the agency to provide additional services. Indeed, the bulk of their funding will continue as it is now. However, the broadening of the mandate of the WTIS to encompasses a much larger set of medical procedures (e.g. all surgery) will contribute to shifting the health care system away from its current global budgeting model and allow it to evolve towards the service based funding model that was strongly advocated by the Senate Committee in its 2002 report.

Enabling the agency to contract for improvements in access that meet specific quality, volume and timeliness standards will allow the agency to take full advantage of its pre-eminent role in the collection of data, monitoring of activity and public reporting to drive wait time reduction forward.

It is critical that this role be played by an independent agency so that these strategic investments are exclusively based on the objectives of wait time reduction and quality improvement.

**Recommendation:** That additional funding be provided on an ongoing basis for the implementation of the wait times strategy.

**Recommendation:** That this funding be controlled by an independent arms length agency that would collect data and report to the public as well as contract for improvements in quality and access with health care providers.
In sections 8 and 9 of this report I have recommended the creation of an arms length agency because I believe that, in most cases, it is likely to have a better chance of success than other organizational models. This can be seen in the excellent results achieved by both the Cardiac Care Network and Cancer Care Ontario.

But other organizational structures can also be effective, as the recent progress on reducing wait times in Ontario shows. Currently in Ontario the data collection and analysis system – the WTIS – is managed by the WTIO and located at Cancer Care Ontario. However, the incremental funding for additional procedures is being managed by the Health Results Team (HRT) that is located inside the Ministry of Health. Although it is inside the Ministry, the HRT is structured so that it is free from traditional bureaucratic processes, allowing it to respond decisively and implement decisions quickly.

In essence, the current Ontario model has most of the characteristics I have recommended in sections 8 and 9 of this report. The only significant difference is that the funding function is performed by the HRT, a unit that, while lodged inside the Ministry of Health, is also independent of the normal bureaucratic structures. It is this independence that is absolutely critical for a reformed wait time system to be successful.

10. Regionalization of Assessment and Wait Lists

The creation of the LHINs in Ontario offers the possibility of better managing wait times by creating single points of access on a regional basis. As the Senate Committee Report (Oct. 2002) noted, regionalization of health care brings numerous benefits to the health care system including reducing administrative costs and allowing for greater flexibility in managing and coordinating resources.¹

A recent initiative in the Champlain LHIN to develop a coordinated model for cancer surgery offers an excellent example of the possibilities of a regionalized system. When fully implemented, this initiative will allow patients to be assessed through a common multidisciplinary site and allocated to those centres within the region that have the capacity and ability to perform the required surgery, even if the patients were first referred into the system through another site. In this way, a single point of assessment and allocation will replace the existing system that is based on individual surgeons controlling patient access through their own wait lists.

A key advantage to a regionalized system for the assessment and allocation of patients is that it enables patients to be treated according to the urgency of their condition on a regional basis, rather than according to their ranking on the list of a single surgeon. This is both a fairer and a more efficient way to proceed.

Initiatives of this type should be encouraged across the province. It can be expected that change along these lines will encounter opposition from people within the system who have grown accustomed to exclusive control over their own wait lists and workloads. Some may even see it as a financial threat because, for them, it could lead to reduced patient volumes and hence reduced income.

However, these obstacles can and must be overcome. We cannot let the particular interests of specific players in the system block reforms that will improve patient access and enhance the quality of service that patients receive.

Recommendation: That efforts to establish single regional assessment centres that enable patient treatment on the basis of region-wide urgency ratings be accelerated.
11. Expansion of the WTIS

The WTIS needs to be expanded in two different ways.

First, and easiest, the number of procedures that are covered by the WTIS needs to be expanded beyond the five procedures that are currently the focus of the wait times strategy (cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements and MRI/CT scans).

It would appear that additional candidates for early inclusion in the WTIS include pediatric, general, orthopedic and ophthalmologic surgery as well as screening colonoscopy.

Expanding the WTIS in this way is a relatively straightforward task. Other provinces are already reporting on a broader range of procedures. Saskatchewan, for example, includes all surgery in its wait time reporting.

Second, the measurement of wait times must start sooner than at the time specialist and patient agree on a particular course of treatment. Wait time measurement should begin as soon as a patient is referred to a specialist and should include the amount of time it takes for a patient to actually see the specialist.

Once this additional time spent waiting is included in the calculation of total wait time, this total will fully represent how patients experience waiting for treatment – that is, the time from when the referral to the specialist is first made until the time the procedure recommended by the specialist is actually performed.

**Recommendation:** That the number of procedures covered by the wait time strategy be continually increased.

**Recommendation:** That the time a patient waits between referral to a specialist and seeing the specialist be recorded as part of the WTIS so that a complete picture of wait times can be established.
12. **Summary**

In less than two and a half years enormous progress has been made in developing and implementing a wait time information and management system in Ontario. These achievements include:

- An information system that provides public reporting on how many Ontarians are waiting for five specified health care services.
- Methodology for measuring these wait times in terms of the relative urgency of each patient’s need for service has been developed and is in the process of being rolled out province-wide.
- Benchmarks have been set as the wait time measures within which the least urgent patients should receive treatment; the more urgent patients would be treated more quickly.
- There has been an increase in system capacity resulting in a not insignificant increase in the number of procedures performed (e.g. 75% more MRI scans, 50% more hip replacements and 38% more cataract surgeries in 2005 than in 2004). This has led to a decrease in wait times of 13% for MRI scans, 20% for hip replacements and 28% for cataract surgeries over the past year.
- The efficiency with which hospitals and specialists manage their wait lists has been improved, resulting both in shorter wait lists and more efficient hospital management.
- And finally, the wait time system is serving as a catalyst for behavioural change by doctors, hospital administrators and patients.

It is very much worth observing that Ontario’s approach to wait time strategy, and the progress that has been made to date in implementing it, have put in place the necessary conditions for establishing the kind of care guarantee that the Senate Social Affairs Committee called for in its October 2002 report.²

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In the first place, accurate data is already being collected that would enable a centralized agency – the WTIS – to monitor individual cases in real time. This means it is possible to know when target times for treatment or diagnostic imaging are being exceeded. The data also allow identification of those hospitals that have the capacity to step in and treat additional patients when a facility whose wait times have exceeded the benchmarks cannot. Taken together, this information would allow the central agency to offer patients, whose original provider could not perform the needed procedure within established target times, the possibility of having their procedure performed elsewhere.

Just as important, the mechanism for funding additional procedures that has been already put in place would allow the central agency to penalize those providers who were not meeting the targets that had been set and whose patients sought speedier treatment at another location because their wait time had exceeded the target. This could be done by withholding or revoking the additional funding that had been granted a provider through the wait times strategy whenever a case had to be dealt with at a different facility. In addition, as an incentive to service providers to shorten their wait times, a penalty could be included to cover additional transportation costs incurred by the patient that required treatment at another facility.

In other words, Ontario is now very close to being able to implement a care guarantee using a system of incentives and disincentives that would be managed by an arms length, impartial agency, just as the Senate Committee recommended.

Given the progress that has been made to date, it appears to me (although I have not examined the data in great detail) that in the fairly short term such a care guarantee could be offered to Ontario residents for cardiac and cataract surgery, with other procedures to follow in the coming years.

Unfortunately, much of the political commentary, some of the media commentary and a few oral remarks made by the Auditor General have not sufficiently acknowledged the progress that has been made to date. Nor has it been adequately recognized that the
implementation of the wait time information system is very much a work in progress. As often happens with respect to public policy issues, some players attempt to score points by focusing on the few things that are not working as well as they should while ignoring those that are performing very well.

In spite of the progress made to date, much more remains to be done. As recommended in this report, the following are among the most pressing items to be tackled:

- The rollout of the system to cover all wait time funded hospitals in the province needs to be completed (target date is the end of 2007);
- The number of services which are included in the wait time information system needs to be increased (e.g. to pediatric, general, orthopedic and ophthalmologic surgery as well as screening colonoscopy);
- The measurement of wait times needs to begin when a patient is referred to a specialist, so that the waiting time to see a specialist is also included in the measure of total wait time (the current system measures waiting time from the decision to treat until treatment is given);
- The number of regional assessment centres needs to be sharply increased so that the urgency of a patient’s condition can be properly assessed on a region-wide basis, thus insuring that those most in need of treatment get treated first; and
- A separate, impartial agency, which is at arms length from government and which has the financial clout to be able to establish and enforce performance measures for the fourteen LHINs in return for additional funding for additional procedures, is absolutely essential.

Finally, in order to build on the success already achieved and accomplish the tasks listed above, more than the $614 million in incremental funding on wait time issues that has been spent in the past two years will be required. The money dedicated to reducing wait times must not be a one-time investment. Increased funding needs to be provided on an ongoing basis, so that hospitals will make the necessary additional capital investments to maintain improved wait time levels.
13. A Final Thought

It would be hard to overstate the importance of continuing the efforts already undertaken to reduce wait times. The need to reduce wait times has implications for the future of the entire publicly funded health care system.

If Ontarians want to preserve the single payer publicly funded health care system that they, along with most Canadians, cherish, then continued investment in, and emphasis on, reducing wait times is imperative.

In the Chaoulli decision of June 2005, the Supreme Court of Canada ruled that governments must live up to their part of the health care contract with Canadians. The Court ruled that if Canadians are not given timely access to medically necessary services, then government cannot prevent patients from paying for such services with their own money. That is, if government is incapable of, or unwilling to, meet acceptable service standards, then government should not be able to prevent the creation of a parallel, privately funded health care system.

In this regard, it is instructive to note that patients referred to the health care system by the Workplace Safety and Insurance Board of Ontario (WSIB) – and in every other province by their respective Workers’ Compensation Board – are already part of a parallel privately-funded health care system.

For example, as the Auditor General noted, “WSIB patients received much quicker access to their MRI examination than did non-WSIB patients.” He added that “81% of WSIB-funded out-patients at one hospital received access to services within two weeks, while only 27% of the other out-patients received access to the same services within two weeks.”

However, the fact that WSIB patients get faster access does not mean that patients waiting in the publicly funded queue wait longer for service. This is because WSIB
patients are treated outside of time slots reserved for publicly funded patients. Thus, WSIB patients do not “bump” publicly funded patients because these patients would not receive treatment outside of publicly funded hours.

The publicly funded time slots reflect the maximum number of procedures that the provincial government will fund at any given hospital. (That is why the additional funding to reduce wait times is, in effect, an expansion of the health care system.) The number of publicly funded time slots – and hence the number of publicly funded procedures – is rationed by the budget capacity of the provincial government. In other words, the annual budget that a hospital receives from the provincial government limits or rations the number of procedures of various kinds the government will pay for, and hence that can be performed at that hospital.

Lack of funding is clearly not the sole cause of a shortfall in the number of procedures performed – indeed, human resource shortages and the way the hospital system is organized may perhaps be even more important causes. But inadequate funding is nevertheless a significant impediment to increasing the number of procedures that are performed.

The private funding that the WSIB puts into the health care system in order to buy quicker access for its clients shows that there remains excess capacity in the system that could be used to perform additional procedures if the money was available to pay for them.

Unless wait times continue to decrease – and they will if the steps recommended in this report are followed – it is to be expected that sometime in the reasonably near future a court will rule that individuals who have been denied timely access within the publicly funded system should be entitled to use their own money to purchase some of this excess capacity. The court is likely to reason that if WSIB patients can use private money to obtain accelerated treatment, then why should individuals not be able to use their own money to do the same thing.
This is why making continued progress in reducing waiting times is so critical.