Evidence Boost

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A series of essays highlighting evidence-based management and policy options

Manage waiting lists centrally for better efficiency

The Issue: Waiting Times

Canadians are steadfast in their support for medicare, but they are also worried about quality and access — especially the concern that waiting times for surgery and diagnostic tests are too long and may even be putting lives in danger.

Fixing the problem with waiting times is a growing preoccupation for all Canadian governments; both federal and provincial leaders have repeatedly stated that timely access to quality healthcare for all Canadians is their first priority. They have promised to manage waiting times better and reduce them if they are longer than is medically acceptable, but how can those commitments be met?

Strategy for Change

Waiting is widely considered an inherent feature of publicly funded healthcare. Health systems around the world are looking for better ways to manage access to health services. Generally, the goal of these efforts is to make the system fair, "such that access to appropriate and effective health care is both timely and prioritized on the basis of need and potential benefit."[i]

Where to begin, though, if you're trying to organize your service or institution better? The first step is to pull together a single, centralized list of everyone waiting for a particular type of care. These centralized lists help address unequal waits for service in a given area — where some patients wait for a year while others wait for a month, depending on the doctor — by showing discrepancies in waiting times and which doctors can see people soonest.

Centralized waiting lists are also essential for the important task of ensuring the sickest people are treated first. Tools exist to assess patients' needs and prioritize them for many treatments, and more are being developed all the time. Centralized lists also provide standardized data, which are important for good management.

The Research Base

With a few notable exceptions, waiting lists are a "non-system" in Canada,[ii] a jumble of names in an individual physician's office. So the first step is to centralize the lists — by province, health region, or institution.

Audits of centralized lists help managers and policy makers better understand the waiting list problem and point to potential efficiencies. Such audits have consistently found that 20 to 30 percent of names shouldn't even be on the list, either because patients got the service elsewhere, didn't want it, no longer needed it, or even died.[iii]

Taking excess names off a list doesn't necessarily shorten waiting times, but it makes it easier to predict how long the waits will be, and to plan and budget accurately. For example, the Cardiac Care Network of

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Ontario uses waiting list management to determine when heart centres are getting backlogged and capacity needs to be added or shared; data are also used to measure results and encourage improvements in care.[iv]

A second crucial feature of central management is the use of objective measures to assess which patients need care most. This "urgency scoring" standardizes the factors physicians consider when ordering treatment, such as the patient's frequency of pain or life expectancy.[v] The score may also include non-clinical factors, such as patient age and work status.[vi]

For example, the Western Canada Waiting List Project has used consensus panels to develop scoring systems for cataract surgery, general surgery, hip and knee replacement, magnetic resonance imaging, and children's mental health. Tests of the mental health priority scoring system found it accurately reflected the severity of patients' illness and clinical practice.[vii] Tests of the hip and knee priority criteria are producing results similar to physicians' judgments of urgency.[viii]

However, even when lists are managed better, there will still be waits unless there are considerable changes in how physicians do their jobs and how health services are run. One need only look to New Zealand, which pioneered urgency scoring as part of a mammoth overhaul of its health system. New Zealand did not set national standards for care and did little testing of the priority scores. Physicians circumvented the list by exaggerating certain symptoms, and there was no guarantee an operation would be funded, even if a patient were judged to need it.

Researchers used the New Zealand experience to identify three key factors for success, which can help those looking to implement their own centralized management of waiting lists: first, there must be system-wide standards, so all patients have the same access to care; second, it must be made clear whether the object of urgency ranking is to set a level below which a procedure will not be paid for or if it's to make patient assessment more transparent and rational; and finally, the validity of scoring methods must be rigorously tested.[ix]

Moving to centralized waiting lists will not be easy. To bring about lasting change, doctors might have to agree to take patients from a central referral service, which would be a huge cultural change, as well as a big administrative task. And no matter how well-managed lists are, or how carefully assessed patients are, in a system where resources are finite, everyone waits for care.

In addition, while classifying patients by urgency may improve efficiency and fairness, it won't actually shorten waiting times unless extra funding and other resources are used to get rid of existing backlogs and then co-ordinate care as new patients arrive.[x] There are models of this approach (called "queuing theory") working, but many administrators fear it requires an unmanageable level of funding and staff.

Conclusion

Centralizing waiting lists is the first step for organizations and jurisdictions that are looking to deliver better care through realistic planning and funding based on good data. They are the basis for ensuring those who need care most get it first, and they are also important in improving quality.

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