Developing a Culture to Sustain Ontario's Wait Time Strategy

INVITED ESSAY

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ABSTRACT

Ontario's Wait Time Strategy – a significant change management initiative – is designed to improve access to healthcare services in the public system by reducing the time that adult Ontarians wait for services in five areas by December 2006 (cancer surgery, cardiac revascularization procedures, cataract surgery, hip and knee total joint replacements, and MRI and CT scans). These five are just the beginning of an ongoing process to improve access to, and reduce wait times for, a broad range of healthcare services beyond 2006.

Change management initiatives are initially successful because of the significant time, attention and resources that are dedicated to the start-up effort. Many initiatives lose their momentum and impact and ultimately fail in the long run since it is difficult to sustain this level of intensity. The probability of success increases if a

culture is developed to sustain the initiative into the future. A pivotal element for this sustained culture is accountability for achieving results. If Ontario is to reduce waits for quality healthcare services over the long term, it must shift from a paradigm where no one – or only a few – are accountable for achieving a particular set of results to one where a wide range of players is accountable for achieving a broad range of results. This includes explicit accountabilities of the public, healthcare providers (including physicians, other healthcare providers, professional associations and regulatory bodies), government and Local Health Integration Networks. Tools required to support these accountabilities include developing leaders, aligning incentives to reinforce what needs to be achieved, and developing information systems to provide the data needed to make decisions, and manage and improve performance.

Let us not waste our time in idle discourse.
Let us do something, while we have the chance.

– Samuel Beckett, *Waiting for Godot*

Introduction

In November 2004, Ontario officially launched the Wait Time Strategy, designed to improve access to healthcare services in the public system by reducing the time adult Ontarians wait for services in five areas by December 2006 (cancer surgery, cardiac revascularization procedures, cataract surgery, hip and knee total joint replacements and MRI and CT scans). These five are just the beginning of an ongoing process to improve access to, and reduce wait times for, a broad range of healthcare services beyond 2006.

Ontario's Strategy is a significant change management initiative that has generated a great deal of momentum. Increased government spending, incentives to help improve efficiencies and effectiveness, and the rigour with which the Strategy is being implemented have been welcomed by hospitals and providers. Although it has not been easy for them to meet the requirements of the Strategy, there is a lot of anticipation in the field about expanding the initiative beyond the original five service areas. More importantly, there is heightened interest in how improvements will be sustained over the long term. Many believe that these improvements will help meet growing demands for healthcare without bankrupting the system. It is neither realistic nor possible to spend increasingly more, considering that health already accounts for over 45% of Ontario's budget. Besides, spending more money is not the answer. Experience in other jurisdictions has shown that increased spending does not result in sustained improvements and can actually lead to overcapacity and inefficiencies (Noseworthy 2003; Harrison and Appleby 2005).

Many change management initiatives are successful – at first – only to lose their momentum and impact over time. One explanation may be the Hawthorne effect, first observed by the Harvard Business School's Elton Mayo and his colleagues in a management research study at the

Hawthorne Plant of the Western Electric Company in Cicero, IL, 1927. A major finding of Mayo et al. was that worker productivity improved regardless of the physical and environmental changes that were made in the workplace. One interpretation was that performance improved because of the attention and interest paid to the workers (Mayo 1946). But another, more compelling explanation is the lack of effort to create a culture in which ongoing improvements and excellence become part of the fabric of how one does business. This culture is one of a self-improving, self-driven system in which the incentives and arrangements become the structure and architecture of the system itself (Barber, quoted in Coleman 2005a), and in which activities focus on safely maximizing the return on investments for the benefit of patients.

Ontario's Wait Time Strategy has a number of key elements crucial to its success. The one element that is absolutely pivotal to develop a sustained culture is accountability for achieving results. When the Strategy began, no one in Ontario was accountable for access to quality healthcare services or the length of time that patients waited for care. Although the Strategy makes hospital boards and management accountable for managing access and waits for five services in their organizations, improved access must go beyond five hospital-based services. If Ontario is to reduce waits for quality healthcare services over the long term, it must shift from a paradigm in which no one – or only a few – are accountable for achieving a particular set of results to one where a wide range of players is accountable for achieving a broad range of results. To paraphrase Barber, when there is a problem in the system, the question cannot be what will government do about it because they have the money, or what will boards and management do because they are "in charge" of organizations. Rather, the question has to be how are we together going to solve the problem (Barber, quoted in Coleman 2005a).

This article examines how to develop a culture to sustain Ontario's Wait Time Strategy through explicit accountabilities for achieving results. The article begins with an overview of the Strategy followed by a discussion of the accountabilities of a wide range of players for sustaining the strategy into the future: hospital boards and management, the public, healthcare providers (including physicians, non-physician healthcare providers, and professional associations and regulatory bodies), government and Local Health Integration Networks. We conclude by identifying three major tools that are required to support these accountabilities and, ultimately, develop the culture to sustain Ontario's Wait Time Strategy.

Overview of Ontario's Wait Time Strategy

Key Elements

Ontario's Wait Time Strategy has a number of key elements, the first of which is *empowering patients* by democratizing knowledge about wait times. As of October 2005, Ontarians now have access to wait time information on a public website. The public is encouraged to use this information to engage in discussions with their providers about where to obtain care.

The Strategy has *increased system capacity with more and better use of resources.* Since it was officially announced in November 2004 to March 31, 2006, an additional investment of $189 million has enabled hospitals to perform 8% more CT scans, 11% more cancer surgeries, 16% more cataract surgeries, 17% more selected cardiac procedures,

32% more hip and knee joint replacements and 42% more MRI scans. This is the largest volume increase in Ontario in over a decade. Hospitals were asked to volunteer the number of additional procedures they could perform over and above their base cases, and estimate the cost per case. The final price per incremental case reflected full operational funding to minimize the impact of additional volumes on hospitals' other activities.

… enhance the role of non-physician healthcare providers who have a significant role to play in resolving many wait time issues.

In terms of making better use of resources, 7 aging MRIs, 27 CTs and 5 diagnostic cardiac catheterization imaging units were replaced, allowing an estimated 120,000 more examinations to be conducted annually using the new MRI and CT scanners. For the first time in Ontario, this equipment was bought in bulk, which resulted in standardized equipment, lower administrative costs, a negotiated best price and service package and substantial savings off the list price for the purchase of the MRIs and CTs. The Strategy also funded 54 innovation and staff education projects focused on efficient practices. In addition, perioperative coaching teams are assisting hospitals to map and analyze their processes, identify improvements and determine optimal human resources and scheduling. The Strategy will be increasing its efforts to enhance the role of non-physician healthcare providers who have a significant role to play in resolving many wait time issues.

The Strategy clearly makes *hospital boards and management accountable for managing access* in their organizations. To get additional wait time case funding, hospitals must sign purchase service agreements that stipulate their accountabilities for maintaining a base volume funded through their global budgets, performing the additional wait time cases, managing the waits for *all* cases (base and additional) and providing wait time and quality information for *all* cases. If hospitals do not meet these conditions, wait time funding is taken back. Hospital boards are accountable for meeting the conditions of the purchase service agreements, governing their hospital's access management strategy, ensuring equitable access to services in their organization and assessing their hospital's performance. Hospital CEOs are accountable for managing access, waits and patient flow within their hospitals. A relatively small amount of additional money is being used to leverage accountability for access for all the procedures in the five service areas. These agreements – signed by hospital CEOs and clinical leaders – will increasingly include more accountabilities for quality, safety, efficiency, appropriate access and outcomes.

The Strategy has been seeking the *expert advice of providers and local communities.* Expert panels made up of clinicians, administrators, researchers and other recognized leaders in each of the five service areas have provided advice on investment criteria, population-based planning targets, patient priority ratings, treatment targets, quality improvements and the organization of services to meet future demands. Four additional panels have focused on surgical process efficiencies, information management, critical care and hospital implementation issues (this panel is being led by the Ontario Hospital Association). In addition, local hospital boards, administrators, physicians and hospital staff are providing advice

on wait time challenges and solutions in *local community consultations.*

The Strategy's focus on *tracking, monitoring and improving performance is being supported by a single provincial wait time information system, standardized data and targets.* The provincial Wait Time Information System (WTIS) is in the process of linking all hospitals participating in the Strategy (i.e., those receiving wait time–funded volumes). In June 2005, work also began on expediting the implementation of a provincial Enterprise Master Patient Index (EMPI), which is being financially supported by Canada Health Infoway. By June 2007, all Ontario hospitals receiving wait time–funded cases will be using the provincial EMPI and WTIS.

On the basis of the advice of the expert panels, Ontario released four standardized priority levels and wait time targets for each of the five service areas in December 2005. Healthcare providers, hospital boards and administrators, and the Ministry are expected to use this information to manage and improve access. Hospital performance is being monitored through audits of compliance with purchase service agreements. Provincially, the Strategy commissioned the Institute for Clinical Evaluative Sciences to review the current state of access to the five services, and conduct an in-depth analysis of volumes, rates and wait times using available databases (e.g., Canadian Institute for Health Information) (Tu et al. 2005). Although these data tend to be one to two years old, ICES will update its analysis annually and – as an independent reviewer – assess progress that has been made to improve access.

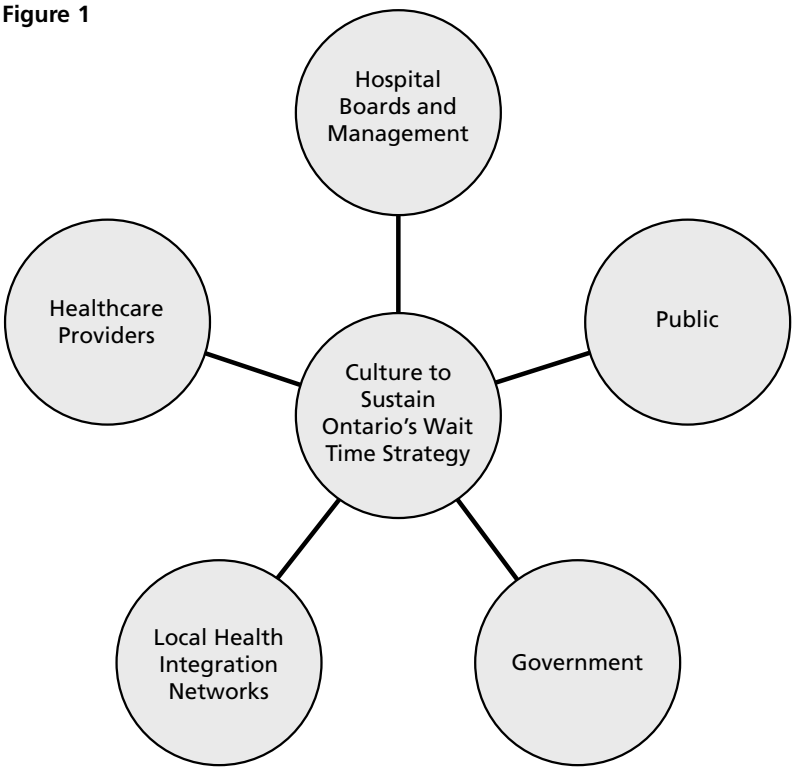
Finally, the Strategy is *demonstrating accountability to the public and providers* in a number of ways. The Minister publicly released all the expert panel reports within a few weeks of their being submitted to his office (see www.ontariowaittimes.com for the Wait Time Strategy expert panel reports) and reported on the Strategy's achievements as part of his progress update on healthcare transformation in Ontario (Ontario Ministry of Health and Long-Term Care 2005). As the system evolves, the 14 Local Health Integration Networks will submit patient safety and quality information to the Ontario Health Quality Council. The Council will report to the public and providers, and highlight areas where improvements need to be made.

To support transparency, a public wait times website was launched in December 2004. As of October 2005, the website began presenting standardized wait time data by procedure, hospital and Local Health Integration Network geographic area. (To date, the site has had over one million hits.) The wait time information currently on the Web reports on patients who have had their procedures, and reflects the time these patients had to wait from the decision to have the procedure to receiving the procedure. By June 2007, hospitals will provide real-time information on the number of patients waiting for a procedure. By mid-to-late 2006, hospitals will be required to submit data on patient priority. Gradually, the site will be expanded to include quality and safety indicators.

An Assessment of the Strategy's Progress to Date

The Strategy's clear focus on reducing waits in five targeted areas has contributed greatly to its progress. The intensity of the rollout, the quickness with which additional funds have been distributed, full operational case funding and the increased volumes are unprecedented in Ontario healthcare. Nevertheless, it has been incredibly complex

Figure 1



to set up the systems, structures and processes to measure and monitor wait times in the five well-defined areas. If the Strategy's focus had been more diffuse and the rollout less intense, fewer if any tangible results would probably be evident after a year. The Strategy will be tracking volumes in other clinical areas to determine whether the wait time focus has impacted on other activities. Effective and efficient practices using available capacity are being documented, and will be shared with hospitals concerned about achieving incremental volumes in the face of other pressures. The Strategy has also promoted the training of anesthesia assistants, and is exploring links with other parts of the continuum of care.

The Strategy has benefited significantly from the expert advice and input of hundreds of healthcare leaders and providers who have voluntarily participated on panels, and attended local community consultations and other meetings. The fact that the expert panels have been made up of individuals rather than representatives of associations and organizations has helped focus the discussions on professional and clinical advice rather than association or organization issues. Panel membership is being expanded to include broader representation to address concerns that large urban acute hospitals have been overrepresented.

Incremental case funding has been viewed very positively, especially in areas that have been severely cut back or relatively ignored in the last decade (e.g., hip and knee joint replacement). Full operational case funding has also been welcomed, although some hospitals are spending money from their global budgets to reopen

or upgrade operating rooms. A major funding challenge is that the Strategy's incremental case funding is inconsistent with global budget funding, which is the main approach used to resource Ontario's hospitals. Fee-for-service funding for physicians is yet a third funding stream that impacts on hospital operations. Advice is being sought from experts in other jurisdictions on aligning these funding streams to improve access and reduce wait times.

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There is widespread agreement that the Strategy is making significant progress in information management, and is leveraging major information developments that have widespread applications beyond wait times. It has been challenging for many hospitals to collect accurate standardized wait time data, and so the initial collection of data was not as smooth as it should have been. The Wait Time Information Office has been assisting hospitals, where possible. It appears that simply providing relevant wait time information has increased the focus of hospitals and providers on access, quality and performance issues.

Finally, a great deal of effort has gone into communicating the Strategy and being as transparent as possible about activities, progress and next steps. Despite best efforts to communicate, the Strategy's communication network needs to be broadened with a greater emphasis on targeted messaging to boards, administrators, medical and hospital staff and the public. In addition, stakeholders who are knowledgeable about the Strategy need to take responsibility for communicating the Strategy to others.

Looking to the Future

Within a year, Ontario has shifted from a culture in which no one was accountable for improving access and wait times to one in which the responsibility has fallen on hospital boards and managers. Although this transformation has been relatively successful in the short term, it will be insufficient to sustain Ontario's Wait Time Strategy into the future. Developing a culture to sustain the Strategy must go beyond limited board and management accountabilities – and beyond a vague concept of shared responsibility – to include explicit accountabilities of the public, healthcare providers, government and Local Health Integration Networks. Each of these groups has a critical role to play in furthering the Strategy's momentum and developing a sustained culture for the future.

Hospital Boards and Management

The Strategy clearly makes hospital boards accountable for the access and wait time performance of their organizations. Management is accountable for operationalizing the board's policies. Local consultations conducted for the Strategy suggest that the ability of boards and management to meet their wait time accountabilities varies across the province. Although efforts are under way to address obvious gaps, hospitals boards and management need to increase their pace, develop requisite skills and take a leading role in a sustained wait time culture.

Actions that hospital boards need to take include the following:

- Boards need to be conversant with the terms of all purchase service agreements that the hospital signs with the Ministry, regularly review their hospital's compliance with funding conditions and hold management accountable for meeting the terms of the agreements.
- Boards need to establish detailed accountability agreements with their CEOs and medical staff that include responsibilities for improving access, reducing wait times and meeting quality and safety improvement and efficiency targets. These agreements underscore the Board's authority to direct and monitor the activities of their CEO and medical staff, and make them accountable for their performance. Renewing CEO contracts and physician privileges should be based on successfully meeting performance and quality targets.
- As a regular item at their meetings, Boards need to review their hospital's wait time data and performance in relation to their peers and other facilities in the Local Health Integration Network, assess areas for improvement and monitor progress to improve performance.
- Boards need to identify opportunities for the hospital to partner with other hospitals and providers in the LHIN to meet the needs of the communities they serve.
- Boards must continuously question whether their decisions and the hospital's operations are safely maximizing the return on healthcare investments for the benefit of patients in the local community and the residents of the LHIN.

Actions that management need to take include the following:

- Management needs to advise their boards, and medical and hospital staff, about government initiatives to improve access and reduce wait times, and outline the hospital's accountabilities for these initiatives.
- Management must engage medical and hospital leadership and staff in decisions about whether the hospital can perform more cases, and ways the hospital can improve access, quality and safety and reduce wait times.
- Management needs to direct and monitor the daily activities of the hospital's physicians and safely streamline the flow of clinical operations. Specifically, managers need to work with physicians to make surgical and patient care processes more efficient and effective.
- Management must increasingly focus their organizations on excellence by establishing goals against which to measure ongoing improvements in quality, safety, efficiency and access.

To help equip boards and management to meet these accountabilities within a sustained wait time culture, boards and managers need to invest in education programs in such areas as access management, effective governance, medical management, determining clinical mandates and strategic planning (Quigley and Scott 2005).

The Public

As healthcare consumers, the public is concerned about access to health services. This concern was brought to the forefront with a recent Supreme Court case, *Chaoulli*, that ruled that waiting an extraordinary length of time to receive necessary services from the public healthcare system in Quebec is contrary to a person's human rights and freedoms. (See *Chaoulli v. Quebec*, June 12, 2005.) Although it may seem counterintuitive to expect that the public has account-

abilities to sustain the wait time culture, Ontarians must do more than just wait in the health services line until their turn comes up for treatment. Actions that the public needs to take include the following:

- The public needs to be proactive and use wait time information to initiate discussions and explore treatment options with their primary care provider. Individuals that do not have access to computers at home or work can access the user-friendly site on publicly available computers (in libraries). Families and friends also need to play an important role communicating wait time information to those who are not familiar with computer technology or statistics, or for whom English is not their first language.
- Although Ontarians have the right to choose the provider they wish to see, healthcare consumers need to recognize that they can contribute to delays in timely access when they choose to wait for a certain surgeon or facility and refuse to take the "next available treatment slot." (This does not include patients in certain parts of Ontario, such as the north and rural areas, where distance and high travelling costs limit choice of provider and facility.) This phenomenon of choosing to wait for a preferred provider has been well documented internationally (Brouwer et al. 2003). For example, the UK's Department of Health's 2004 autumn performance report to Parliament found that when 125,800 patients who had been waiting about six months were offered the choice of faster treatment, only 19% took up the offer (Harrison and Appleby 2005). Although distance to treatment may have been a factor, the British London Patient Choice Project found that after waiting several months, a significant number of people chose to wait longer for treatment at their local or first-choice hospital when they were offered a shorter wait at another hospital *within London* (University of York, forthcoming, as reported in Harrison and Appleby 2005). The authors hypothesized that the degree of discomfort the patients experienced was modest.
- Patients need to show up on time for scheduled procedures or give sufficient notice if they cannot appear. (Similarly, providers need to ensure that scheduled procedures go ahead and that surgical throughput is efficient. The Strategy found that 29% of Ontario's hospitals did not even track whether operations started on time.) A 2001 review of cancelled surgeries in Britain found that slightly over half of cancellations for nonclinical reasons occurred on the day of surgery (National Health Service 2001). Although the most common reason for cancelled surgery was unavailability of a ward bed (23%), 21% of cancelled surgeries were due to patients not attending, 7% because the patient no longer required the surgery, and 4% due to an inconvenient appointment time.
- Healthcare consumers need to understand that there are limits to what medicine and healthcare services can realistically achieve. Anecdotal evidence suggests that patients and their families are increasingly demanding expensive treatments that have little or no impact on final outcome. For example, critical care in Ontario is often provided to patients who do not, or can no longer, benefit from this level of care (Bell and Robinson 2005). A dilemma occurs when patients and relatives with increasing expectations that a critical care bed

should be available for all seriously ill patients are faced with professional providers who view critical care as a resource to be used only if it will provide some benefit. The public needs to actively engage with providers in ethical discussions about setting priorities and the limits of medicine.

The media have an important role to play in educating the public by communicating the existence and content of the wait time website, featuring stories on how the public can use wait time information to discuss treatment options with their providers, "personalizing" what the Strategy has meant to consumers in terms of access to services, writing investigative articles on the impact of consumer choice, behaviour and expectations on wait times, and exploring ethical issues in medicine and healthcare services.

Healthcare Providers

Over the past 30 years, many health professions in Ontario have increased their educational qualifications, and have become more specialized and skilled. The extensive body of theoretical and technical knowledge that was the domain of a small monopolistic core of professional groups has become more dispersed among a wide range of healthcare providers. Many of these providers have a crucial role to play sustaining the wait time culture. This goes beyond having a sufficient number of appropriately qualified providers to reassessing what each provider does, and ensuring that each provides services to the maximum level of their training and skills (Trypuc and Hudson 2005).

Physicians

When the Strategy began, there were no levers to hold physicians accountable for achieving wait time results. Now, medical leadership and management must co-sign purchase service agreements before the hospital gets wait time funding. Many hospitals have further developed medical accountabilities by requiring physicians to provide patient data before surgical procedures can be booked. Although these changes are notable, they are insufficient to sustain the Wait Time Strategy into the future. The following physician-related actions are needed to maintain the momentum:

- Clear accountability levers need to be established between Ontario hospitals and their medical staff. Although physicians generate the vast majority of hospital costs, they are not directly accountable for managing these resources. Rather, most hospital physicians are accredited to these organizations through privileges and are paid fee-for-service by government. (A relatively small number of physicians are paid through alternative funding programs.) The traditional notion of hospital "privileges" – which suggests that physicians have a vested right to practise in hospitals – needs to evolve into annual hospital-based physician performance and quality contracts. These should stipulate mutual accountabilities of physicians and hospitals, as well as performance targets for quality outcomes, safety, efficiencies and effectiveness.
- The Canadian Medical Association's *Code of Ethics* (2004) notes that physicians must "[recognise their responsibility] to promote equitable access to healthcare resources" and "[use] healthcare resources prudently." (This insight was presented by Guilbert 2003.) Increasingly, in a wait time culture, physicians will be faced with conflicts between their responsibility to the

individual patient in front of them and to other patients on the waiting list or those who are not yet on the waiting list (Guilbert 2003). To equip physicians to address these issues, medical students need to be taught cost-benefit and ethical decision-making skills. Physicians working in hospitals need basic information on the cost of health services, training on how to incorporate cost-benefit and ethical considerations in clinical decisions, and leadership and management training. This will strengthen the physician–management partnership and focus it on improving access. As one physician observed, "Physicians and administration can't just get together four times a year and yell at each other."

"Healthcare leadership needs to demonstrate how it will serve patients' interests …

- Physicians need to work more actively in teams with non-physician healthcare providers. Although studies have shown that physicians support the delivery of health services using a multidisciplinary team approach, the nature of the perceived team (physician-driven) may be at odds with the broader consensus within the health field of how teams should function (Triska et al. 2005). Physician concern about legal liability in a team situation is a fundamental issue that needs to be addressed. As well, hospitals need to support training on developing effective multidisciplinary health teams, and include team performance in hospital-based physician contracts.
- The Strategy is democratizing knowledge about wait times and will provide increasingly more information on wait time options to primary care providers. In turn, these professionals need to use this information to discuss choice of provider with their patients. This is contrary to current practice, in which patients are usually referred to specialists whom their primary care provider knows or has used in the past. A recent report from the National Audit Office (2004) in the UK found a reluctance among general practitioners to exploit the potential for choice on behalf of their patients. Providers need to facilitate quicker access to specialized care for their patients by encouraging various treatment options.

Other Healthcare Providers

Non-physician healthcare providers have a significant role to play in resolving many of the wait time issues. As part of the Strategy, many healthcare providers have welcomed and indeed actively lobbied to expand their skills and "do more." They have not been so quick to assess the tasks for which they are overqualified and which might be performed by others. To sustain the wait time culture into the future, non-physician healthcare providers need to examine critically their scopes of practice in relation to their education and expertise, and identify the tasks that can be performed by others.

The Role of Professional Associations and Regulatory Bodies

One of the goals of professional associations and regulatory colleges is to protect the interests of the public; however, this public protection role is first and foremost through the lens of the membership of these groups. The Strategy's underlying human resources principle is that healthcare providers should

deliver services to the maximum level of their training and skills; other services should be performed by other professionals with appropriate changes to professional scopes of practice or by nonregulated providers with appropriate training and supervision.

- To sustain the wait time culture into the future, professional associations and regulatory colleges need to enable innovative and nontraditional human resources approaches that are supported by scope of practice changes, appropriate credentialling and training.
- Healthcare leadership needs to demonstrate how it will serve patients' interests, respond to changing public and political expectations and support healthcare reform.

Government

Government includes politicians who set priorities and directions, and civil servants who operationalize these priorities. The relationship between these two elements of government is a complex one. Politicians focus their activities within their mandate – about four years in Ontario – before they face another election. In contrast, civil servants use policies and procedures that have been well honed over a long period of time. Both components of government working in tandem are crucial for a sustainable wait time culture. This can be difficult, since processes and outcomes that are politically uncomfortable may be politically contested as they are being implemented (Barber, quoted in Coleman 2005a). Furthermore, there may be vested interests or a perceived inability to change unhelpful policies and procedures that have become routine over time. The following government actions are needed to sustain the momentum into the future:

- The Strategy has benefited from the strong support and commitment of the province's top politicians and civil servants. Government needs to maintain its tangible support and commitment to improve access and reduce wait times as a top priority.
- Appropriate and consistent practices that support wait time goals are needed to sustain the Strategy into the future. Some improvements have occurred. For example, when a large number of hospitals that received wait time funding did not provide agreed-upon deliverables on time, rather than take a permissive approach consistent with past-practice, hospitals were quickly informed that they would be declared noncompliant on the public website, that funds would be withdrawn if cases were not completed and that noncompliance would affect future allocations. All hospitals quickly complied. By following through with tough – and potentially unpopular – consequences, the Strategy "rewarded" good performance and maintained a credible reputation. Consistently applying this approach is needed to sustain the Strategy into the future.

Local Health Integration Networks (LHINS)

Although regional authorities are common in most provinces in Canada, as well as other jurisdictions (such as the United Kingdom, Norway and Sweden), Ontario has just established these entities (*Local Health System Integration Act,* 2006). Ontario's 14 Local Health Integration Networks (LHINs) are responsible for planning, integrating and funding local health services for their specific geographic areas. Actions that the LHINs need to take to sustain the wait time culture include the following:

- LHINs need to identify clinical wait time leaders for each of the Strategy's program areas. Each leader should work with providers in the LHIN to develop procedures so that residents receive timely and appropriate access to services. Examples include monitoring wait times, developing patient referral processes and facilitating collaborative approaches to address local access issues (e.g., which services will be provided in the LHIN and where, inter-hospital referrals, medical coverage in smaller communities, physician remuneration, blockages to timely access).
- LHINs that will not provide highly specialized services for their residents locally need to establish formal partnerships with other LHINs to ensure timely and equitable access to services.

Supporting Tools

A number of tools are needed to support the accountabilities identified above and to ultimately develop the culture to sustain Ontario's Wait Time Strategy. Three supporting tools are particularly critical:

- *Develop leaders.*
- *Align incentives* so they support what you want to achieve.
- *Develop information systems* that provide the data needed to make decisions, and to manage and improve performance.

Develop Leaders

Strong leaders focused on improving access and reducing wait times need to be developed throughout the system.

Hospital boards – which represent the interests of the citizens of the local community and the taxpayers of Ontario – are public leaders. They must lead by establishing an organizational vision for the Wait Time Strategy, asking probing questions on behalf of their communities and holding management and medical staff accountable. Hospital management needs to lead by maximizing the skills and expertise of medical and hospital staff to meet the Board's vision.

Healthcare providers need to develop profession-specific leaders who can focus the spotlight on the contribution each profession can make to improve access and reduce wait times. Respected leaders who can promote multidisciplinary approaches are also needed to shine a wider spotlight on how the professions can work together for the benefit of the patient.

Government leaders – both political and in the bureaucracy – need to adopt a relentless commitment to achieve sustained wait time results. Specifically, these leaders need to establish a long-term provincial vision for Ontario's Wait Time Strategy, target ongoing investments that are linked to conditions and support the use of clear and consistent government practices to achieve the vision. Local Health Integration Networks need to lead by ensuring that their planning, integrating and funding decisions are improving access and reducing wait times for residents in their regions.

Leaders throughout the system must look beyond their organizational and professional interests to promote the best interests of the public, as consumers of healthcare. Leadership skills can be developed through education and mentoring programs in areas such as strategic planning, managing change, understanding data, setting targets, monitoring activity, improving and rewarding performance, delivering results, building teams and communicating effectively. Great leaders also need to develop "a set of attitudes with ambition, urgency, drive, persistence, thinking of a problem as something that you solve rather than an excuse for not

delivering" (Barber, quoted in Coleman 2005a).

Align Incentives

Appropriate incentives are needed to improve access and reduce wait times, and disincentives are needed if these goals are not met. This is especially important in systems that have little or no element of competition. If healthcare providers have a monopoly, their customers cannot be demanding and, as a consequence, the providers will not be demanding either (Martin 2006). When the risk of losing or running out of business does not exist – as in Ontario's public healthcare system – a competitive-type environment must be created that gives providers appropriate incentives to improve performance or meet targets. These incentives should support the reforms that one is trying to achieve. The following actions will help sustain the wait time culture.

Report Publicly Hospital Wait Times and Performance. Public and peer scrutiny is a powerful incentive to improve access and reduce wait times. Anecdotal evidence suggests that public reporting is resulting in performance improvements. More information on quality should be made public. As well, it may be useful to develop composite quality indicators or an access and wait times report card. For example, the UK's National Health Service uses a publicly reported star-rating system to measure the overall performance of trusts. Five of the nine targets are related to waiting (Harrison and Appleby 2005). Initially the ratings were used to distribute a small performance fund, but they have since been expanded to help identify potential candidates for foundation trust status, among other things (e.g., identify trusts that needed special attention such as senior management team improvement).

Align Hospital and Physician Funding Streams. Physicians are paid fee-for-service, which incentivizes them to treat as many patients as possible. In contrast, hospitals receive global budgets, which incentivize them to treat as few patients as possible since there is no profit to be made in doing more cases. The importance of aligning hospital and physician funding streams to sustain Ontario's Wait Time Strategy is increasingly being recognized throughout Ontario.

Align Physician Fees to Support Government Healthcare Priorities. The physician fee schedule, which outlines the fee associated with each medical procedure, is not totally aligned with government's healthcare priorities. Surgeons and anesthesiologists may perform procedures that are less time-consuming, less complex and more financially lucrative even though these procedures do not support the government's healthcare priorities. For example, orthopedic surgeons can make more money doing many short procedures such as arthoscopes rather than performing more complex and time-consuming hip and knee replacements. As well, even though anesthesia skills are critical to support surgical activities, anesthesiologists are also financially incentivized to perform activities outside the operating room. Physician fees need to be aligned to support government healthcare priorities to sustain the Strategy.

Payment for Performance. Payment for performance links a hospital's income to the amount of work it performs by paying a set fee for each procedure. Payment for performance acts as an incentive to perform more procedures as efficiently and effectively as possible. Although the Strategy's use of payment for performance has resulted in increased volumes, greater efficiencies, more transparency and clear accountabilities for volumes and quality, its overall impact

remains limited; the Strategy's funding only makes up a very small proportion of the total funding hospitals receive. Many countries use payment for performance in healthcare with generally positive results, although it does have its challenges (Drouin and Hay 2005; McKinsey and Company 2005; Audit Commission 2005). Payment for performance is as much about a change in culture as it is about incentives and payments (Audit Commission 2005). It can be complex, time- and resource-intensive and challenging; and, consistent with Ontario's limited experience, it can highlight weaknesses in the healthcare system. Although introducing wide-scale payment for performance is not a simple matter and can take time to see positive impacts, it needs to be explored as part of sustaining the wait time culture.

"… information should be used to manage – and not just measure – performance, and should focus on results.

Develop Information Systems

Healthcare tends to be characterized by an overabundance of information and a slavish attention to measuring and collecting data, with little attention paid to using appropriate measures to manage and make improvements. A recent Ontario review (conducted by Dr. Adelsteinn Brown, Lead of Information Management, as part of the Ontario government's Transformation Agenda introduced September 2004) of almost 100 health information databases with about 2,000 performance indicators found duplications, poor data quality and indicators of limited use that were difficult to interpret, provided little information or did not relate to the government's key health priorities (Ontario Ministry of Health and Long-Term Care 2005). It is easy to create and collect information; it is more challenging to reduce it and make it useful. "The comparative advantage [has shifted] from those with information glut to those with ordered knowledge, from those who can process vast amounts of throughput to those who can explain what is worth knowing and why" (Heclo, quoted in Shenk 1997).

It is challenging to identify the most useful data to support a sustained culture for wait times. Public sector executives and government leaders have more diverse and complex outcomes to deliver than the shareholder value that is the focus in the private sector (Coleman 2005b). The challenge of improving access and reducing wait times necessitates taking a broader focus that includes many outcomes:

- Healthcare consumers need information on how long they may be expected to wait and the appropriateness of that wait. Providing additional information on quality of care and outcomes (e.g., infection rates, mortality) will increase patient choice and transparency, and better assist patients and their primary care providers to make treatment decisions. Efforts need to go into making this information accessible to diverse populations that have different languages, cultures, reading levels and comfort levels with using computer technology and statistics.
- Healthcare providers and managers need appropriate information to assess their wait time performance compared

to targets within their hospital and between hospitals. This information should be used to manage – and not just measure – performance, and should focus on results. Good results should be rewarded and poor results should entail consequences.

- Funders need wait time information to assess performance against well-defined targets. LHINs will use this information to target where additional investments and capacity are needed, where performance should be improved with additional skills or procedures and where to align incentives with desired outcomes. In this area, the UK has been successful in bringing down wait times with a forensic and ferocious attention to numbers and being tough on anyone who does not measure up (personal communication between John Bacon, the National Health Service Group Director, London, and Alan Hudson, November 3, 2005). Eventually, funders will need to collect the full continuum of wait times, identify bottlenecks in patient flow, monitor trends and make adjustments where required.

Concluding Remarks

In Beckett's play *Waiting for Godot*, Vladimir advises his companions: "Let us not waste our time in idle discourse. Let us do something, while we have the chance." Perhaps it is fitting when thinking about this advice to recall that Beckett was associated with the theatre of the absurd. Indeed, it would be absurd to assume that the gains and momentum generated by the Wait Time Strategy thus far will ensure its ongoing success into the future.

A number of conclusions can be drawn. First, change management initiatives are initially successful because of the significant time, attention and resources dedicated to the start-up effort. Since it is difficult to keep up this level of intensity, many initiatives lose their momentum and impact and ultimately fail in the long run. The probability of success increases if efforts are made to develop a culture that will sustain the initiative.

Second, a sustained wait time culture will only be successfully developed in Ontario if a wide range of players – hospital boards and management, the public, healthcare providers, government, Local Health Integration Networks – fulfil their accountabilities as identified in this paper. These accountabilities reflect a behavioural shift that makes everyone responsible for achieving wait time results.

Finally, many believe that sustaining the Wait Time Strategy is Ontario's best chance to meet the growing demands for healthcare without bankrupting the system. Thomas Kuhn (1970) observed that probably the single most prevalent claim advanced by the proponents of a new paradigm is that they can solve the problems that have led the old one to a crisis. Those who embrace a new paradigm must have faith that it will succeed with the many large problems that confront it. Our own problems include healthcare expenditures that account for over 45% of Ontario's budget, the lack of clear accountabilities for results, incentives that perversely work against wait time reforms and lengthy wait lists for certain services. If Ontario is to meet these challenges in a public healthcare system, it really has no option but to develop a culture to sustain the Strategy that focuses on more effective and efficient use of resources, clear accountabilities and improved access.

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