

# Ontario's Wait Time Strategy: Part 1

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## Introduction

The Canadian public and healthcare providers are concerned about access to healthcare services and long waits for diagnostic tests and treatments. Opinion polls indicate that two-thirds of Canadians felt that they waited too long for healthcare services over the past year, and most Canadian physicians reported feeling that their patients face unreasonable delays for orthopedic surgery, diagnostic imaging, cardiac care and cancer treatment (Ipsos-Reid/Canadian Medical Association February 2004). Interest in wait times for healthcare has been heightened with recent investments through the federal Wait Times Reduction Fund, the Chaoulli Supreme Court ruling 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 (*Chaoulli v. Quebec*, June 12, 2005), the release of pan-Canadian benchmarks for selected procedures (December 12, 2005) and an increasing debate on the role of private healthcare in Canada.

The provinces and territories are addressing wait time issues in various ways. These efforts have either been kick-started or

spurred on by the 2004 agreement between the federal, provincial and territorial First Ministers of Health to achieve meaningful reductions in wait times in at least five areas by March 31, 2007: cancer, cardiac, diagnostic imaging, joint replacements and sight restoration (2004 Annual Conference of Federal-Provincial-Territorial Ministers of Health, *National Waiting Times Reduction Strategy*). Although Ontario has been successfully measuring and monitoring waits in cardiac surgery and radiation therapy,<sup>1</sup> at the time of the agreement the province did not yet have valid and reliable wait time information to help determine where problems exist, how serious they are and what to do about them.

In November 2004, Ontario's Minister of Health and Long-Term Care, George Smitherman, officially launched the Wait Time Strategy as part of a broader package of initiatives to transform the province's health system. (The other initiatives included developing a regional planning system through 14 Local Health Integration Networks, creating Family Health Teams for primary care, building information systems and encouraging greater community involve-

1. The Cardiac Care Network of Ontario has been recognized nationally and internationally for its work on standardizing wait information for cardiac surgery, catheterization, angioplasty and stents. Patient access and wait times are monitored provincially, regionally, locally and within individual hospitals. Cancer Care Ontario collects waiting times for radiation therapy and also monitors this information provincially, regionally, locally and within individual hospitals.

ment in planning.) Ontario's Wait Time Strategy was 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 (cardiac surgery, percutaneous coronary intervention, diagnostic catheterization), 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. The end result will be better patient care for all Ontarians.

This article is the first in a series of articles examining Ontario's Wait Time Strategy. The series begins with the Strategy's key elements, assesses progress made after one year, and identifies the lessons learned thus far. The second article will examine the work of the Wait Time Strategy's expert panels, the third article will explore the impact of surgical efficiencies and critical care on improving access and reducing wait times, and the final article will be a retrospective review of the success of the Strategy as it finishes its third year.

Undoubtedly, many readers will recognize the elements of the Strategy since they have been borrowed or adapted from wait time approaches used in other countries, provinces and in Ontario itself (e.g., Cardiac Care Network of Ontario). The way in which these elements are being implemented and the successes and challenges to date reflect a made-in-Ontario approach that is influenced by provincial priorities and systems of care.

**Key Elements of Ontario's Wait Time Strategy**

The Wait Time Strategy is a significant change management initiative that reflects a cultural shift in the role of patients and providers, access management and accountability. The Strategy's key elements are:

- Focusing on empowering patients and providing them with choice
- Increasing system capacity with more and better use of resources
- Identifying who is accountable for access in formal agreements

Figure 1. The Wait Time Strategy: Phases I-IV

Phases	Actions
<b>Phase I</b> <b>Labour Day 2004 – March 31, 2005</b>	<ul style="list-style-type: none"> <li>• Initiate the Wait Time Strategy.</li> <li>• Initiate the purchase service approach and gain momentum and buy-in from the field.</li> <li>• Provide initial funding for additional volumes in targeted areas.</li> <li>• Establish funding conditions that demand hospital accountability for wait times and agreed-upon volumes.</li> <li>• Increase efficiency and processes by investing in newer equipment.</li> <li>• Audit and obtain feedback from hospitals about case distribution, pricing, and ability to meet conditions, and accelerate into Phase II.</li> </ul>
<b>Phase II</b> <b>April 1, 2005 – March 31, 2006</b>	<ul style="list-style-type: none"> <li>• Continue to focus on efficiency and standardization in hospitals.</li> <li>• Increase the sophistication of funding conditions to include quality.</li> <li>• Continue targeted volumes to address backlogs.</li> <li>• Continue fostering a competitive environment where volumes are allocated to hospitals that provide efficient, cost-effective, quality care and use procedure rates per 100,000 population to support equity of access across LHIN geographic areas.</li> <li>• Develop prioritization and outcome tools and targets.</li> <li>• Develop a single provincial information system and collect wait time data.</li> <li>• Develop models that relate targets, benchmarks, volumes and dollars to guide decision-making.</li> <li>• Develop policies for diagnostic imaging and critical care.</li> <li>• Reinforce accountabilities.</li> </ul>
<b>Phase III</b> <b>April 1, 2006 – March 31, 2007</b>	<ul style="list-style-type: none"> <li>• Continue targeted volumes to clear backlogs and start reducing wait times. Use modelling from the end of Phase II to inform decisions on additional cases to be allocated.</li> <li>• Continue developing information systems, establish an Enterprise Master Patient Index, collect wait time data on patients waiting and the length of those waits, and establish registries for the five service areas.</li> </ul>
<b>Phase IV</b> <b>April 1, 2007</b>	<ul style="list-style-type: none"> <li>• Use models to forecast demand, supply and capacity for the five service areas, provincially and by LHIN geographic areas.</li> <li>• Fund the systems to "right size" and support activities.</li> <li>• Expand the access management program beyond the original five service areas.</li> <li>• Establish a structure to support a rolling five-year plan for access management in Ontario.</li> </ul>

- Seeking the expert advice of providers and local communities
- Tracking, monitoring and improving performance using a single wait time information system, standardized data and targets
- Demonstrating accountability to the public and providers

Figure 1 summarizes the four phases of the Strategy and the detailed action steps in each phase.

### Focusing on Empowering Patients and Providing Them with Choice

The Strategy empowers patients by democratizing knowledge about wait times. Ontarians now have access to wait time information on a public website and have been encouraged to engage in discussions with their providers about choosing where best to get their care.

### Increasing System Capacity with More and Better Use of Resources

The Strategy is increasing the capacity of hospitals to perform more procedures by funding additional cases and making better use of resources. Although Ontario has traditionally allocated case funding for selected programs, a unique feature of the Strategy is that hospitals were asked to volunteer the number of additional procedures they could perform over and above their base cases, and to estimate the cost per case. Hospitals volunteered to do three times more procedures than were planned for Phase I, and at widely different costs. A final price per case was set for incremental volumes after consultation with the Joint Policy and Planning Committee, an Ontario Hospital Association–Ministry of Health and Long-Term Care collaboration. The case price reflected full operational funding to minimize the impact of additional volumes on hospitals' other activities. In Phase I, the Strategy allocated \$35 million to selected Ontario hospitals in November 2004 to increase the number of cancer surgeries, cardiac procedures, hip and knee replacements, cataract surgeries and extended MRI hours by March 31, 2005.

In Phase II, hospitals were once again asked to volunteer the number of additional procedures they could perform at the rates set in Phase I. Using criteria that included rates of procedures by Local Health Integration Network (LHIN) geographic areas and success in meeting Phase I targets, \$154 million was allocated to hospitals to cover case funding in the five selected areas in fiscal 2005/06. This funding supported the incremental volumes allocated in Phase I plus additional procedures in Phase II. These investments were to begin reducing the backlog of patients waiting for procedures.

Since the Strategy was officially announced in November 2004 to March 31, 2006, hospitals have received funding to perform 8% more CT scans, 11% more cancer surgeries, 16% more cataract surgeries, 17% more selected cardiac procedures, 28% more hip and knee joint replacements and 42% more MRI scans. This is the largest volume increase in Ontario in over a decade.

The Strategy is also increasing capacity through more efficient and effective use of capital, operating and human resources.

With regard to capital resources, seven aging MRIs, twenty-seven CTs and five diagnostic cardiac catheterization imaging units were replaced in Phase I. An estimated 120,000 more exams can be conducted annually using the new MRIs and CTs. For the first time in Ontario, this equipment was bought in bulk, which resulted in standardized equipment across hospitals, 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.

With regard to operating resources, the Strategy funded 29 hospitals and three provincial organizations to conduct 54 innovation and staff education projects focusing on efficient practices. In addition, peri-operative coaching teams – made up of peers with peri-operative management experience – are assisting hospitals to map and analyze their processes, identify improvements and determine optimal human resources and scheduling.<sup>2</sup> Ultimately, coaching teams will improve access through system efficiencies and standardized processes and best practices.

With regard to human resources, everyone agrees that a sufficient number of appropriately qualified human resources is needed to reduce wait times. There is also widespread agreement that healthcare providers should deliver services to the maximum level of their training and skills. The Strategy maintains that non-physician healthcare providers have a significant role to play in resolving many of the wait time issues. These providers include nurse practitioners, registered nurse first assistants, physician assistants, physiotherapists, physiotherapy assistants, occupational therapists, occupational therapy assistants, kinesiologists, anaesthesia assistants and others. The Strategy will increase its efforts in enhancing the role of non-physician healthcare providers in 2006.

### Identifying Who Is Accountable for Access in Formal Agreements

When the Strategy began, no one in Ontario was accountable for making sure that patients had appropriate access to healthcare services. Although the Ministry allocates global budget increases and selected program funding to hospitals each year, generally these funds do not come with explicit accountabilities

2. Peri-operative includes pre-operative, operative and immediate post-operative care.

for maintaining or improving access to services. In contrast, the Strategy clearly makes hospital boards and management accountable for managing access in their organizations.

Hospitals must sign purchase service agreements to get additional wait time case funding. These agreements clearly stipulate that hospitals are accountable 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.

A unique feature of purchase service agreements is that a relatively small amount of additional money is being used to leverage accountability for access for all the procedures in the five service areas. To meet the conditions of the agreements, surgeons must provide the necessary patient information to hospitals so that surgeries can be booked and waiting times tracked. Hospital boards are accountable for the accuracy and completeness of the data, governing their hospital's access management strategy, ensuring equitable access to services in their organization and assessing their hospital's performance. CEOs are accountable for managing access, waits and patient flow within the hospital.

Another unique feature of purchase service agreements is that hospital CEOs and clinical leaders must sign these agreements for additional funding. These individuals have to agree on the number of additional cases that can be performed and need to collaborate to meet funding conditions.

In Phase I, the Strategy's main focus was to increase the number of procedures being performed. In Phase II, this focus has been expanded to include accountabilities for quality, safety, efficiency and appropriate access. The 2005/06 purchase service agreements include surgical efficiency conditions, surgical access management processes to support equitable access, MRI efficiency targets and qualitative measures for cancer surgery. Conditions that will be added in 2006/07 include patient priority ratings that link urgency with wait time targets.

### Seeking the Expert Advice of Providers and Local Communities

Expert panels made up of clinicians, administrators, researchers and other recognized leaders in Ontario are helping shape the Strategy by providing ongoing advice to government. Panels in each of the five service areas have advised on the criteria for ongoing investments, population-based planning targets, patient priority ratings, treatment targets, quality improvements and organizing services to meet future demands. Four additional panels have focused on surgical process efficiencies, information management, critical care (to ensure that surgical delays and cancellations are minimized) and hospital implementation issues (this panel is being led by the Ontario Hospital

Association). In addition to providing expert advice, the panels have also communicated information, championed improvements and developed wait time leaders. All expert panel reports have been made public (Figure 2).

**Figure 2. Wait Time Strategy expert panel reports**

1. *MRI and CT Expert Panel Phase I Report* (Dr. Anne Keller, Chair), April 2005.
2. *Optimizing Access to Advanced Cardiac Care: A 10 Point Plan for Action* (Cardiac Care Network of Ontario), March 2005.
3. *Report of the Cancer Surgery Expert Panel* (Dr. Jonathan Irish, Chair), September 2005.
4. *Report of the Cataract Surgery Expert Panel* (Dr. Phil Hooper, Chair), July 2005.
5. *Report of the Ontario Critical Care Steering Committee* (Dr. Robert Bell and Lynda Robinson, Co-chairs), March 2005.
6. *Report of the Surgical Process Analysis and Improvement Expert Panel* (Valerie Zellermeier, Chair), June 2005.
7. *Report of the Total Hip and Knee Joint Replacement Expert Panel* (Dr. Allan Gross, Chair), September 2005.
8. *Report of the Wait Time Information System Expert Panel* (Sarah Kramer, Chair), June 2005.

All reports are available on: [www.ontariowaittimes.com](http://www.ontariowaittimes.com).

Senior Strategy managers regularly meet with local hospital boards, administrators, physicians and hospital staff to obtain feedback on local challenges and solutions to wait time issues. This local expertise is used to gauge what is working well and to identify where adjustments need to be made. Local media briefings are scheduled during community consultations to educate the broader community about the Strategy. These briefings have been particularly successful in smaller communities that are intensely interested in local access to healthcare.

### Tracking, Monitoring and Improving Performance Using a Single Wait Time Information System, Standardized Data and Targets

The Wait Time Information System (WTIS) is linking all hospitals participating in the Strategy (i.e., those receiving wait time funded volumes). The creation of a single system is unprecedented in Ontario where individual or small groups of hospitals typically decide which information system to buy. Considerable progress has been made on building the provincial WTIS since planning began early in 2005. Clinical leaders from the expert panels and hospitals that received additional cases in Phase 1 provided detailed input into the design of the system. In June 2005, work began on expediting the implementation of a provincial Enterprise Master Patient Index (EMPI) along with the WTIS. Canada Health Infoway has committed funding to implement the EMPI.

Five hospitals will implement the EMPI and the WTIS by March 31, 2006 (reflecting almost 20% of the incremental wait time cases). By December 2006, about 55 hospitals will have implemented the system (accounting for 80% of all cases) and by June 2007, all Ontario hospitals receiving wait time funded cases will be using the provincial system.

Standardized wait time indicators have been developed based on the advice of the clinical expert panels (e.g., definitions of waiting for an MRI/CT or surgery, standard clinical assessment criteria, patient priority levels). A standardized approach to priority levels and targets was also developed across all five areas. The Wait Time Information Office is monitoring compliance with data reporting and working with hospitals to address issues of compliance and data quality. If hospitals do not submit their data on time, they are reported as “non compliant” on the public wait times website.

The Strategy is using the concept of targets against which to measure performance.

- On December 16, 2005, Ontario-specific targets – including priority levels and wait time targets for each level – were released for each of the five service areas. Healthcare providers, hospital boards and administrators, and the Ministry are expected to use patient priorities and targets to manage and improve access.
- Performance is being monitored through audits of compliance with purchase service agreements. A year-end audit of Phase I found that all of the 2004/05 wait time targets were achieved. Although some hospitals were unable to complete all their allocated cases in 2004/05, this was offset by some hospitals that overperformed and conducted more volumes than they were allocated.
- The Strategy commissioned the Institute for Clinical Evaluative Sciences to review the current state of access to the five selected services, and conduct an in-depth analysis of volumes, rates and wait times (Tu et al. 2005). The report includes wait times from 2003/04 obtained from various data sources. The ICES analysis was used to identify regions with particular wait time challenges and to inform the allocation of additional cases. ICES will update its analysis annually and – as an independent reviewer – assess progress that has been made to improve access.

### Demonstrating Accountability to the Public and Providers

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. He also publicly reported on the progress made transforming

Ontario's healthcare system over the past year, which included the Strategy's achievements (Ontario Ministry of Health and Long-Term Care 2005).

- The Strategy will report its progress to the Ontario Health Quality Council, an independent body that is monitoring the province's healthcare system and reporting to the public on access and the overall health of Ontarians.
- The Ministry notified hospitals about their incremental wait time volumes and additional funding at the beginning of the fiscal year rather than later on in the year as consistent with usual funding practice. This enabled hospitals to begin performing additional procedures immediately. A public wait times website was launched in December 2004 and included general information on wait times (see [www.ontariowaittimes.com](http://www.ontariowaittimes.com)).
- In April 2005, the site presented ICES' analysis of wait time data for the five services by province and the 14 LHIN geographic areas, and in October 2005, the website began presenting standardized wait time data by procedure, hospital and LHIN geographic area. In the first six weeks of presenting individual hospital data, the website had over 425,000 hits. Wait times data for August – September, as reported by hospitals that received wait time funding, were on the web by mid-December. Data will be updated every two months. By mid- to late-2006, hospitals will be required to submit data on patient priority. 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. Gradually, the website will be expanded to include quality and safety indicators such as hospital infection rates, hospital readmission rates and other key indices.
- The field receives regular updates on the Strategy, local media briefings are held at all the community consultations and media interviews are regularly scheduled to coincide with the Strategy's major accomplishments.

### An Assessment of the Strategy's Progress after One Year

The Strategy has made a great deal of progress in one year. Like any significant change management initiative, the Strategy can boast of positive achievements and identify challenges that need attention.

### The Focus and Intensity of the Strategy

The clear focus on reducing waits in five targeted areas has contributed greatly to the Strategy's progress. The intensity of the rollout, the quickness with which additional funds have been allocated and distributed to five areas, full operational case

funding and the increased volume of activity are unprecedented in Ontario healthcare. It is expected that if the Strategy's focus had been more diffuse and the rollout less intense, fewer if any tangible results would be evident after a year. Some hospitals and providers have raised concerns that spotlighting five selected areas may be directing attention away from other clinical areas and other parts of the care continuum (e.g., wait time to see a primary care provider and specialist). The community consultations have also highlighted concerns about achieving incremental volumes in the face of hospital operating deficits, limited capital funds, high occupancy rates and shortages of medical and hospital staff (nursing and anesthesia in particular). Several hospitals are especially concerned with the number of alternative level of care patients in acute care beds, which limits the hospital performing additional surgeries. To address these concerns, the Strategy will track volumes in all areas, has documented more effective and efficient use of current capacity (especially MRIs, CTs and operating rooms), has promoted the training of anesthesia assistants, and is exploring how to link other parts of the continuum to the Strategy.

### **Expert Advice from Providers and Local Communities**

The Strategy has benefited significantly from the expert advice and input of hundreds of healthcare leaders and providers who have voluntarily participated on expert 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 on association or organization issues. Concerns have been raised that large urban acute hospitals have been overrepresented on expert panels at the expense of smaller community and rural facilities. Efforts have since been made to include representatives from the 14 LHIN geographic areas on each panel.

### **Funding Incremental Cases and Linking Them to Accountability for Access**

Hospitals and providers view incremental wait time case funding very positively. Additional funding is especially welcomed in those 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 have pointed out that they must spend money from their global budgets to reopen operating rooms that have been closed or are being used for other purposes.

There appears to be widespread agreement that linking additional funding to clear accountabilities is improving the provision of health services. Hospitals and providers are becoming more aware of the length of wait times, the importance of quality standards and efficient practices, the need for

administrators and clinicians to work together and the imperative of meeting the conditions of purchase service agreements.

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. The challenge is to align these diverse incentive streams to support the particular goals of the Strategy and the general goal of improving access to care. This would ensure that all hospitals are accountable for access and not only those that receive additional wait time cases. Currently, advice is being sought from experts in other jurisdictions on aligning funding streams.

### **Wait Time Information Management**

There is widespread agreement that the Strategy is making significant progress in information management. As well, the Strategy's momentum and profile are helping to leverage major information developments that have widespread applications beyond wait times. For example, the provincial Wait Time Information System and the Enterprise Master Patient Index are providing the foundation for an electronic health record and are being designed to support the needs of other electronic health initiatives (e.g., Picture Archive and Communication Systems or PACS).

It has been challenging for many hospitals to collect accurate standardized wait time data. Hospitals have had to establish internal processes to collect data, verify the accuracy of the information submitted by providers and submit the required information for publication on the website. Not surprisingly, 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 is anticipated that hospitals will find it easier to comply with the data requirements with each successive transferral of the data.

### **Communications**

A great deal of effort has gone into developing messages and communication methods and into being as transparent as possible about activities, progress and next steps. Despite best efforts to communicate as widely as possible using different methods, the Strategy's communication network needs to be broadened with a greater emphasis on targeted messaging to boards, administrators, medical and hospital staff, and to the public. In addition, there is a need to instill in stakeholders who are knowledgeable about the Strategy a responsibility to communicate the Strategy to others.

### **Maintaining the Momentum**

The Strategy appears to have heightened awareness in Ontario that positive change is happening in healthcare. There is a

great deal of enthusiasm about the additional investments and an appreciation of the rigour with which the Strategy is being implemented. There is also a lot of anticipation about expanding the access management program beyond the original five service areas as planned in Phase IV of the Strategy. The field has repeatedly emphasized the need for a clearly articulated long-term plan.

### Lessons Learned

A number of key lessons have been learned in the first year of this major change process.

1. Leadership and commitment from senior levels are essential for progress and success. The Strategy has benefited greatly from the strong commitment of Ontario's Premier, the Minister of Health and Long-Term Care and the Deputy Minister. This level of support has heightened the Strategy's profile both publicly and within the bureaucracy. In addition, the Strategy's Leader – who has strong clinical and administrative experience and expertise and is neither a politician nor a member of the Ministry bureaucracy – is regarded as a credible and objective spokesperson for the Strategy.
2. It is incredibly complex to set up the systems, structures and processes to measure and monitor, what appear to be, fairly simple wait times in five well-defined areas. In its efforts to develop a foundation to support a comprehensive approach to access management, the Strategy has highlighted a number of limitations of the current healthcare system. These limitations have confirmed the original decision to concentrate on a limited number of procedures, learn from experts in these areas, build on the experience with five service areas and refine the Strategy's approach in the short and longer term. A number of significant decisions have been made with this longer-term vision in mind. For example, the design of the information system will support the collection of wait times for other procedures, and the decision to develop a consistent patient classification tool will serve as an effective template when the Strategy expands into other areas.
3. It will take time to see reduced wait times in all five selected areas. The Strategy focuses on a number of procedures that have been a low priority for investments in the past (e.g., hip and knee joint replacements). Since these areas have a significant backlog of patients who need treatment, increasing the number of procedures will not immediately reduce wait times. Furthermore, the demand for certain procedures is increasing due to the aging and growing Ontario population, who need more health services, more effective diagnostics, new clinical indications for treatment and technological innovations. Wait times will decrease when the backlog of patients is treated and the number of additional procedures outpaces increases in demand. Anecdotal evidence from

hospitals, providers and even patients suggests that waits have gone down in Ontario in certain areas. Where and how much this is happening will become clearer as the website presents more data.

4. The provision of healthcare and the economics of healthcare appear to be two solitudes that need to be brought more closely together if wait times are to be addressed effectively. These solitudes are symbolically reflected in Ontario hospitals where physicians generate the vast majority of costs yet are not directly accountable for managing these resources. Although many providers are fully aware of the rising costs of healthcare and are willing to discuss the economics of care and health returns on investments, there are many others who feel the solution to long wait lists is simply to provide more money and/or introduce private healthcare. Currently, health expenditures account for 45% of Ontario's budget and could easily account for more if left unchecked. Indeed, both public and private coffers could easily be swallowed up by rising healthcare costs. Bringing the two solitudes together entails addressing such issues as the ethics of access, divergent funding methods, and innovative ways to provide care.
5. A readiness to embrace the Strategy's changes is not uniform across organizations and providers. Sociologists have observed that groups typically focus on meeting the needs of their members and resist changes that may jeopardize the interests of the group. The Strategy's emphasis on democratizing knowledge about wait times, supporting the patient's right to engage in discussions about choice of provider, and promoting innovative ways to use valuable healthcare resources more effectively has been met with some indifference and even active resistance, especially from some elements of the medical profession. Yet others see the Strategy as an opportunity to bargain for more resources in exchange for support. The Strategy is a significant change management initiative that is gathering momentum. As the public gets more information about their healthcare, it will – rightly so – want more. All healthcare players have a responsibility to support the participation of patients in their care and to ensure that they are getting the best value for their healthcare dollars.
6. Finally, strong leaders are needed at all levels of healthcare. This leadership – which must be evident in regional and provincial associations, on hospital boards, in administration, in medical management levels and among frontline providers – includes taking on new roles and responsibilities to improve access and reduce wait times for all healthcare services. The Ontario Hospital Association has provided an important leadership role through its wait times expert panel and sponsorship of numerous public meetings. Likewise, many boards, administrators, physicians and other healthcare providers have also demonstrated leadership. More

needs to be done. There is an urgent need to develop a cadre of leaders, particularly among healthcare providers, who will become actively responsible for improving access. It is also essential that these individuals continue to guide and participate in the Strategy.

### In Conclusion

The Strategy is a significant change management initiative whose successes are largely due to the thousands of dedicated individuals across the province who are helping to implement this transformation initiative. It has not been easy for organizations and providers to “ramp up” suddenly, increase the number of procedures and hours of operation, collect and submit accurate wait time information in a timely manner, and reassess their processes. But many have. A great deal of effort has gone into meeting these challenges, helping develop solutions and participating in changes that will improve access to healthcare services. 

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