REDUCING SURGICAL WAIT TIMES

THE CASE FOR PUBLIC INNOVATION AND PROVINCIAL LEADERSHIP

By Andrew Longhurst, Marcy Cohen and Dr. Margaret McGregor

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Summary

THE CROSSROADS IN SURGICAL CARE

OVER THE LAST 10 YEARS, a number of successful initiatives in BC have offered excellent examples of how to solve the problem of long wait times. Yet these initiatives—led by local groups of surgeons, health authority administrators and practitioners—have not been scaled up province-wide due to a lack of provincial leadership.

Since 2010, surgical wait times have increased significantly for three out of four key surgical procedures and BC's waits are now among the longest in the country.

We are now at an important crossroads in the future of surgical care in BC. Since 2010, surgical wait times have increased significantly for three out of four key surgical procedures (hip replacement, knee replacement and cataract surgery) and BC's waits are now among the longest in the country.

The provincial government's most recent response to the problem is a 2015 policy paper, *Future Directions for Surgical Services in British Columbia*. While the paper includes many good ideas, the government proposes to move in two contradictory directions at the same time:

- **On the one hand, the report is the first comprehensive discussion of the need for more provincial leadership to reduce surgical wait times.** The report includes some very positive recommendations that mandate the province to take greater leadership on data management and coordination, and strategies to improve patient flow. However, there is no concrete plan for how local efficiency improvement initiatives will be scaled up province-wide.

- **On the other hand, the report makes a firm recommendation to extend the length of stay in private surgical facilities for up to three days—a direction that the College of Physicians and Surgeons of BC recognizes would sanction a for-profit hospital sector.** BC would become the first province to allow three-day stays in for-profit facilities, putting it on the forefront of health care privatization (currently, private clinics are only allowed to perform day surgeries). This proposal comes at a time when we are already seeing a significant contracting out of surgical services. In April 2015 the Vancouver Island Health Authority announced plans to contract out 55,000 day procedures over the next five years—a move that will give the for-profit surgical sector a greater foothold in BC.

The problem with going in these two directions at once is that it undermines the urgency of public sector innovation and takes us farther down the road of health care privatization.

THE PROBLEMS WITH PRIVATE, FOR-PROFIT DELIVERY OF SURGICAL SERVICES

The BC government knows that for-profit health care delivery destabilizes our universal health care system. In fact, the government is drawing on a large body of international research evidence and expert testimony in its defense of BC's public health-care system against a Charter challenge involving Brian Day—a vocal proponent of privatization and the co-owner of the for-profit Cambie Surgery Centre. A large body of international research shows that the problems with private, for-profit delivery of surgical services include:

- **Private, for-profit delivery is more expensive.** This is a result of higher administrative costs, the requirement to return profits to investors, and additional costs associated with creating and enforcing regulations for private providers.
- **Private, for-profit delivery is lower quality and less safe.** For-profit facilities often cut corners to reduce costs—typically through lower staffing levels of skilled personnel—leading to lower quality care and higher mortality rates.
- **Private, for-profit delivery can lead to more inappropriate surgeries.** When physicians have a financial stake in for-profit facilities, medical decision-making is susceptible to conflict of interest leading to inappropriate surgeries that do not provide a health benefit, are risky or result in a patient's health status declining. But as the BC government knows from its audit of Brian Day's clinics, for-profit providers' operations are often shrouded in secrecy, making it difficult to effectively monitor surgical appropriateness.
- **Private, for-profit delivery destabilizes the public system.** The BC government's proposal for up to three-day stays in private hospitals will likely give multinational corporations, specifically US hospital chains, a foothold in BC. Doctors of BC warns that contracting out "easy" procedures to the private sector may destabilize the public system.

A large body of international research shows the problems with private, for-profit delivery of surgical services.

Methodology

This study provides an extensive review of Canadian and international policy literature and peer-reviewed evidence on the problems with private, for-profit surgical delivery. It also draws on 18 key-informant interviews with surgeons, health authority administrators and health policy experts. The policy recommendations build on best practices from BC and Saskatchewan as well as Scotland—a global leader in public sector wait-time solutions.

A BETTER WAY FORWARD: BECOME A LEADER IN PUBLIC INNOVATION

BC can learn from other jurisdictions in Canada and abroad, such as Scotland's ambitious work to significantly reduce wait times and improve health outcomes over the past two decades. The Canadian Wait Time Alliance—comprised of 18 national medical organizations—identifies Scotland as a global leader in developing long-term public sector wait-time solutions while also improving the quality of care patients receive.

The Saskatchewan Surgical Initiative—a four-year program (2010–2014) to reduce surgery wait times to three months from surgery booking to completion—also shows how public sector innovation can reduce waits and improve care.

How does BC compare?

- In Saskatchewan in 2015, 99 per cent of knee replacement patients received surgery within 26 weeks of booking the procedure. In BC, only 47 per cent of knee replacement patients received surgery within this time period.
- In Scotland in 2015, wait times were even shorter: 90 per cent of all trauma and orthopaedic surgery patients[1] were treated within 12 weeks.
- Scotland has an integrated approach to tracking three different wait times—the time from family doctor referral to seeing a specialist, the time from surgery booking to completion, and the time from referral to receiving diagnostic tests (e.g. MRI scan). BC only reports one waiting period that patients encounter—surgery booking to completion.

This study revisits the state of innovative public sector initiatives from BC that have been effective at reducing wait times to see specialists and receive surgery.

Successful local innovations suffer from a lack of provincial leadership to make them standard practice province wide. This study revisits the state of innovative public sector initiatives from BC originally featured in the CCPA's 2007 report, *Why Wait? Public Solutions to Cure Surgical Waitlists*, that have been effective at reducing wait times to see specialists and receive surgery:

- By moving day surgeries into specialized procedure rooms, the **Mount Saint Joseph Hospital Cataract and Corneal Transplant Unit**, has seen continued improvement, with the average wait time at eight weeks, down from 12 to 16 weeks in 2007. Status: Operational and successful, yet not scaled up.
- The **Osteoarthritis Service Integration System**—a team-based clinic with nurses and occupational and physical therapists—quickly assesses patients' appropriateness for surgery, preventing patients who aren't suited to surgery from filling waitlists, and allowing surgeons to focus on the most urgent patients. Status: At risk.
- **Richmond Hip and Knee Reconstruction Project**—an operating room efficiency initiative—brought median wait times for hip and knee replacement surgery down by 75 per cent, from 20 months to five months. Status: Terminated.

The following features of successful public sector innovations are supported by the international research evidence and build on best practices implemented in Scotland:

- **Maximize surgical capacity and optimize operating room performance in the public system.** Eighteen per cent of operating rooms in public hospitals are not regularly staffed, primarily because of inadequate funding, and none have extended hours. Doctors of BC—and even the BC government—state that existing public sector capacity should be fully utilized.
- **Actively manage waitlists through a centralized "first available surgeon" referral system.** Wait times vary widely across surgeons and specialty areas. BC should move to centralized management of these waitlists by health authorities to give patients more choice by allowing family doctors to refer them to the first available surgeon.

1 This represents the closest comparison available.

- **Teamwork** allows patients to receive specialist consultation and surgery faster. When health professionals—nurses, physical and occupational therapists, etc.—working in multidisciplinary teams are supported to work to their full scope of practice, it can free surgeons' time to perform additional surgeries and consult with patients who have the most urgent need.

- **Reduce inappropriate surgeries** by supporting physicians to implement shared decision-making in their practice so patients are actively involved in the decision to undergo surgery or pursue non-operative therapies based on the best available evidence.

- **Modernize and integrate information systems** to support data-driven waitlist management strategies and quality improvement innovations. Like Scotland, BC should accurately monitor and report on the entire patient journey, including wait times for specialist consultation, diagnostic testing and surgery completion.

- **Improve access to community and home care.** Better access to affordable, high quality residential care and home health care, especially for seniors, will reduce hospital bed shortages, cancellations of elective surgeries and, ultimately, wait times for all patients.

- **Better align physician compensation to reduce wait times and support system change.** The dominant compensation model in BC—self-employed physicians working as fee-for-service contractors—is a barrier to implementing changes that would reduce wait times and improve patient outcomes (a centralized "first available surgeon" referral system, teamwork, etc.).

BC should accurately monitor and report on the entire patient journey, including wait times for specialist consultation, diagnostic testing and surgery completion.

But for these public sector innovations to be implemented in BC, there must be provincial leadership and commitment to:

- **Establish an on-going and provincially coordinated process for improving publicly delivered surgical services.** Scotland has been working in a consistent direction for 20 years providing national leadership to regional authorities to support front-line providers making on-the-ground quality and efficiency improvements.

- **Create improvement teams provincially to work with local providers to spread system-wide best practices.** Improvement teams play a critical role in promoting and entrenching effective local innovations system-wide.

- **Fully commit to investing in the public services and infrastructure necessary to reduce surgical wait times to take the pressure off overcrowded hospitals.** More residential care beds and home health care are required to support frail seniors and others who occupy hospital beds because community alternatives are not available.

Introduction

IN 2007, THE CANADIAN CENTRE FOR POLICY ALTERNATIVES (CCPA) published *Why Wait? Public Solutions to Cure Surgical Waitlists*. The report examined innovative public sector strategies and models from BC and elsewhere that have been very effective in reducing wait times to see specialists and receive surgical care. *Why Wait?* raised serious concerns about the lack of leadership from BC's provincial government to support and expand successful local innovations and make them standard practice across the province. Instead, the provincial government floated the idea of funding incentives that would, among other things, expand the opportunities for private, for-profit clinics to deliver publicly funded surgical services. As the authors of *Why Wait?* pointed out at the time, if the private route is the road the provincial government chooses, "waitlists in the public system will only grow longer and the prediction of [the public system's] unsustainability will become a self-fulfilling prophecy."[1]

Waitlists are growing longer for many key surgical procedures and BC is, once again, at a crossroads.

Now 10 years later, waitlists are again growing longer for many key surgical procedures and BC is, once again, at a crossroads. With an aging population, growing demand for surgeries and evidence of a fragmented and inefficient system, the BC government recognizes the need for a "systemic approach to change that builds a truly patient-centred system of care."[2] The choices are clear. The provincial government can address the root causes of the problem and introduce system-level improvements in how surgical services are delivered in the public system—a strategy strongly supported by the international evidence—or it can abdicate its leadership role and turn to the private sector in search of a solution.

In early 2015, the BC Ministry of Health and the Provincial Surgical Executive Committee released *Future Directions for Surgical Services in British Columbia*,[3] the first comprehensive provincial policy statement on how to reduce wait times by changing how surgical services are delivered. The *Future Directions* paper outlines the BC government's strategy for tackling wait times and, while it includes many good ideas, it proposes pursuing two contradictory policy directions at the same time. On the one hand, the report recognizes the need for more provincial leadership and describes several local public sector innovations for reducing waits—though it fails to address the critical issue of how these innovations are scaled up across the province. On the other, the report makes a firm recommendation to extend the length of stay in private surgery clinics for up to three days. Currently, private surgical clinics are only allowed to perform day surgeries, which

1 Priest et al., 2007, p. 7.
2 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 47.
3 Ministry of Health and the Provincial Surgical Executive Committee, 2015.

limits the type and complexity of procedures they can offer. With the proposed change, BC would become the first province to allow up to three-day stays in for-profit facilities.

Effectively the proposal for up to three-day overnight stays would sanction a private hospital sector, putting BC on the forefront of publicly funded, private health care delivery in Canada. This proposal comes at a time when we are already seeing a significant expansion of private sector surgical delivery. In April 2015, the Vancouver Island Health Authority announced plans to contract out 55,000 day procedures over the next five years—a move that will give the for-profit surgical sector a greater foothold in BC (see page 12, *Assessing the BC government's proposed policy direction*).

The BC government knows that increasing the role of private, for-profit health care delivery undermines our universal health care system. The provincial government is going to court to defend BC's public health-care system against a Charter challenge launched by a group of plaintiffs led by Brian Day, a vocal proponent of private health care and co-owner of the for-profit Cambie Surgery Centre.[4] The plaintiffs argue that for-profit clinics and physicians enrolled in BC's public system should be allowed to charge patients as much as they want for medical services and that legislation should not prevent the sale of private insurance for publicly insured services. While the primary issue in the Charter challenge is not publicly funded private surgical delivery, the case does provide important context to understand the BC government's contradictory position on private health care. In response to the lawsuit, the provincial government has drawn upon a large body of evidence to demonstrate how private, for-profit health care delivery, and not just private insurance, will undermine the public health care system (see *The Day case*, below).

The proposal for up to three-day overnight stays would sanction a private hospital sector, putting BC on the forefront of publicly funded, private health care delivery in Canada.

Our report begins by providing an extensive review of Canadian and international policy literature and the peer-reviewed evidence on the problems with private, for-profit surgical delivery. In addition to a literature review, this report draws on 18 key-informant interviews with surgeons, health authority administrators and health policy experts (see list of interviewees in Appendix A). Our policy recommendations build on public sector wait-time solutions implemented in Scotland and Saskatchewan. The BC government has important lessons to learn, especially from Scotland, which has shown strong leadership in reducing wait times by implementing system-level surgical improvement strategies in the public system without relying on private-sector delivery.

4 Fuller, 2015.

The Day case

A GROUP OF PLAINTIFFS LED BY Dr. Brian Day, an orthopedic surgeon and vocal proponent of private health care, is challenging the constitutionality of BC's legislation that protects the province's universal health care system. In 2007, the Medical Services Commission, responsible for managing the Medical Services Plan (MSP) on behalf of the BC government, informed Day that his for-profit clinics (Cambie Surgery Centre and Specialist Referral Clinic) would be audited because the Medical Services Commission had received patient complaints about improper billing. Before the Commission could conduct the audit, a group of plaintiffs led by Day (including four private clinics that have since withdrawn) launched a Charter challenge against provisions of the BC Medicare Protection Act that prohibit both private insurance and private pay for publicly insured medical services.[5] The plaintiffs asked the court to delay the audit until a final determination on their Charter challenge was made. While a temporary stay of the audit was granted, Day's clinics were finally audited in 2011 with "limited cooperation from the President [Brian Day], management, and staff."[6] The June 2012 BC government audit report found extensive illegal extra-billing and overlapping claims to MSP by Day's clinics. Specifically, it found:

A group of plaintiffs led by Dr. Brian Day is challenging the constitutionality of BC's legislation that protects the province's universal health care system.

- "extra-billing had occurred at both Specialist Referral Clinic and Cambie Surgery Centre on a frequent and recurring basis, contrary to the Act;
- "the extra-billing would often overlap with physician claims of MSP;
- "charges to beneficiaries [patients] for benefits rendered at Specialist Referral Clinic or Cambie Surgery Centre by opted-out physicians,[7] exceeded the value of what the beneficiary could claim from MSP, where [the auditors] could determine such MSP values; and,

5 For an analysis of the court case, see Fuller, 2015. The plaintiffs are challenging four sections of the BC Medicare Protection Act that prevent doctors enrolled in medicare from: (1) billing both patients and the medical plan for the same service, (2) charging facility fees or extra-billing above the fees established by the medical association and (3) charging private insurers for services covered by the Medical Services Plan. The BC Ministry of Health, the Medical Services Commission and the BC Attorney General are defendants in the case. The BC Health Coalition and Canadian Doctors for Medicare were successfully granted intervener status to ensure crucial arguments about the importance of medicare would be heard.

6 Ministry of Health, 2012, p. 5.

7 If physicians are "opted out", they are still enrolled in MSP and may bill patients directly for their services up to the amount paid by MSP. Patients then claim full reimbursement from MSP. By law, physicians may not charge patients more for an insured benefit than the prescribed MSP amount, so patients can be fully reimbursed by MSP.

- "a high degree of business relationships existed between Specialist Referral Clinic, Cambie Surgery Centre and their physicians with respect to extra billings or charges exceeding what a beneficiary could claim from MSP."[8]

That is to say, "not only were patients unlawfully charged for insured health care services at the Cambie Surgery Centre and Specialist Referral Clinic, but physicians in the clinics were doing so with the benefit of a very substantial public subsidy by submitting claims to, and receiving payments from, the Medical Services Plan for services that 'overlap' with those for which patients have paid privately."[9] In late 2015, the Medical Services Commission was granted permission to audit the doctors at Day's clinics who they suspect are double-billing based on the preliminary evidence from the 2012 audit findings.

At the time of writing, the trial is expected to resume in June 2016. The BC government is drawing upon 34 expert witnesses[10]—physicians, senior health administrators, academics, and health policy experts—who have submitted affidavits providing expert testimony of the problems of both private, for-profit delivery and private insurance. Many of these expert witnesses are leading health policy scholars who have published widely in peer-reviewed journals and whose research has identified significant problems with private, for-profit health care delivery—evidence the BC government itself references in its defence of universal health care.

In late 2015, the Medical Services Commission was granted permission to audit the doctors at Day's clinics who they suspect are double-billing.

8 Ministry of Health, 2012, p. 4.

9 BC Health Coalition, 2014.

10 The number of experts is based on the BC government's revised trial brief dated January 8, 2015.

Assessing the BC government's proposed policy direction

The vast majority of health professionals and citizens favour public, not private, solutions for improving health services.

FOR MORE THAN 10 YEARS there have been pockets of innovation with local groups of surgeons, health authority administrators and clinicians experimenting with new approaches to delivering surgical services within the public system.[11] And although these experiments may have required some additional funding, their primary aim was to reduce wait times through the more effective and efficient use of existing resources. The BC Ministry of Health, on the other hand, over these years has been focused almost entirely on short-term infusions of additional funding and incentives to complete more surgeries—measures that have a poor record of reducing wait times over the long term.[12]

The idea of volume incentives was first introduced by Brian Day (who was at the time the president-elect of the Canadian Medical Association) at the opening conference of BC's Conversation on Health in the fall of 2006.[13] His proposal borrowed heavily from health reforms in England, where National Health Service hospitals were mandated to compete with each other and for-profit surgery centres for patients and funding for elective surgeries. The goal of BC's Conversation on Health was to seek input from health professionals and citizens around the province on how to address health system challenges. Through these discussions, it became clear that the vast majority of health professionals and citizens favoured public, not private, solutions for improving health services. As a result, the volume incentives proposed by Day were put on hold for three years and were reintroduced in 2010 by then-Minister of Health Kevin Falcon as a way to reduce wait times and shift more procedures to day surgeries. From 2010 to 2013, the province invested $250 million in this venture.[14]

The record of success in reducing wait times since 2010 is not promising. In 2010, Canada's Wait Time Alliance—comprised of 18 national medical organizations—found BC to be meeting national benchmarks and, in fact, doing better than most provinces on the four key surgical

11 Priest et al., 2007.
12 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 38.
13 Cohen et al., 2012, p. 20.
14 BC Ministry of Health, 2010.

Table 1: Wait times for surgical patients

Wait 1	GP referral to surgical consultation
Wait 2	Surgery booking to completion of surgery
Wait 3	Referral to diagnostics to completion of diagnostic testing (e.g. MRI scan)
Wait 4	Surgery completion to patient recovery

Table 2: Percentage meeting wait time benchmark, April to September 2015, by province

	Hip replacement (26 weeks)	Knee replacement (26 weeks)	Hip fracture repair (48 hours)	Cataract surgery (16 weeks)
BC	61% ▼	47% ▼	91% ▲	64% ▼
AB	83% –	79% ▲	86% ▲	64% ▲
SK	100% ▲	99% ▲	80% –	96% ▲
MB	69% ▲	64% ▲	92% ▲	41% †
ON	87% –	86% –	86% ▲	74% ▼
QC	85% –	80% –	*	88% –
NB	68% –	62% ▲	86% –	84% –
NS	52% –	36% –	85% ▲	64% ▲
PEI	87% ▲	91% ▲	77% –	87% ▲
NL	94% ▲	87% ▲	85% –	96% ▲

▲ At least a 5-percentage-point *increase* meeting benchmark since 2011 (after rounding to nearest per cent)
▼ At least a 5-percentage-point *decrease* in percentage meeting benchmark since 2011 (after rounding to nearest per cent)
– No substantial change in percentage meeting benchmark since 2011.
† Manitoba's 2015 results incorporate changes in methodology and coverage and therefore are not directly comparable with results from previous years.
* Quebec wait times for hip fracture repair are not included due to methodological differences in the data.
Note: Benchmarks used are pan-Canadian benchmarks established in 2005.
Source: Adapted from Canadian Institute for Health Information, 2016, Figure 3, p. 6.

procedures (hip replacement, knee replacement, hip fracture repair and cataract surgery).[15] By 2015, wait times—from the time from surgery booking to its completion (Wait 2; see Table 1)—had increased significantly in three out of four of these procedures (hip replacement, knee replacement and cataract surgery) and BC's wait times in these very key surgical areas are, now,

15 Wait Time Alliance, 2010; see also Canadian Institute for Health Information, 2011.

among the highest in the country (Table 2).[16] According to the provincial government the median wait time for surgical patients across all surgical areas decreased slightly from 11.3 weeks in 2009/10 to 10.7 weeks in 2013/14.[17] The slight decrease overall in median wait times may be attributed to short-term strategies, such as activity-based funding incentives and one-time injections of health care dollars to work down backlogs—strategies that, according to the research literature, are ineffective at promoting long-term wait-time improvements.[18] And interestingly, funding models to incentivize greater surgical volume and reduce wait times (i.e., activity-based funding and pay-for-performance), for now, appear to have been put on hold.

In 2015, the BC Ministry of Health and the Provincial Surgical Executive Committee released *Future Directions for Surgical Services in British Columbia* (henceforth, *Future Directions*), the first comprehensive provincial policy statement on wait time reductions. The 28-member Provincial Surgical Executive Committee is composed of surgeons, representatives from the health authorities, Ministry of Health, the BC Patient Safety & Quality Council, as well as two patient representatives.[19] The Provincial Surgical Executive Committee "has been given the mandate and authority to drive the identification and implementation of surgical improvement actions built on the principle of a collaborative partnership between patients, the health authorities and physicians supported and enabled by the Ministry of Health, the BC Patient Safety & Quality Council, relevant health professional Colleges, the Doctors of BC and relevant unions."[20]

The Ministry of Health's process—driven by the Provincial Surgical Executive Committee—lacks public transparency. We have found it difficult to obtain even the most basic information about the Committee's membership and activities.

However, the Ministry of Health's process—driven by the Provincial Surgical Executive Committee—lacks public transparency. Considering the stated intent for the process to be collaborative and patient-focused, we have found it difficult to obtain even the most basic information about the Committee's membership and activities. The membership is not posted publicly on the Ministry's website, and names were provided to us reluctantly. Furthermore, we were refused a copy of the plan guiding the committee's efforts that would provide insight into how the report's recommendations are being prioritized and what the public might expect from this surgical care reform process.

We subsequently filed a Freedom of Information request to obtain the work plan, which revealed timelines for specific initiatives but provided no detail as to how actions will be accomplished.[21] Consequently, we are at a considerable disadvantage evaluating how the Provincial Surgical Executive Committee is prioritizing its work and what improvement efforts are under way. We therefore have to rely on the *Future Directions* policy paper and interviews with key informants, including surgeons and health authority administrators, to establish an understanding of the committee's activities and the broader surgical care strategy.

The BC government's *Future Directions* paper, for the first time, acknowledges the need for more provincial coordination and leadership to reduce wait times and health care costs, improve health outcomes and the patient experience.[22] The report includes some very positive recommendations that mandate the province to take greater leadership on data management and coordination

16 Canadian Institute for Health Information, 2016; see also Wait Time Alliance, 2015.

17 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 26. These medians capture only Wait 2. Currently, the BC Ministry of Health data used in the Surgical Patient Registry captures only the wait from the hospital's receipt of the surgery booking form from the surgeon's office to the surgery completion. See Table 1 for definitions of wait times used by the BC Ministry of Health and in this report.

18 Ibid., p. 38; Borowitz et al., 2013, p. 67; Cohen et al. 2012.

19 See Appendix B for Provincial Surgical Executive Committee membership list.

20 Ministry of Health and the Provincial Surgical Executive Committee, 2015, pp. 47–48.

21 The Provincial Surgical Executive Committee work plan, obtained through a Freedom of Information request, is available at: http://docs.openinfo.gov.bc.ca/Response_Package_HTH-2015-53819.pdf.

22 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 1.

and strategies to improve patient flow. In addition, the report describes a number of excellent examples of public sector innovations. But the key improvements needed at the provincial level to ensure that these innovations are implemented system-wide are not reflected in the report's recommendations. Instead, the report recommends contracting out surgeries by allowing up to three-day overnight stays in private facilities—a proposal that makes little sense given the fact that 18 per cent of public hospital operating rooms are not regularly staffed and none have extended hours (see page 23, *Why not use existing public sector surgical capacity?*). The recommendation to contract out surgical services appears to be driven, in part, by hospital overcrowding and too many patients, often the frail elderly, occupying inpatient beds because affordable, high quality community alternatives are not available. Yet, the *Future Directions* paper does not prioritize an integrated provincial strategy to fully utilize existing surgical infrastructure and improve access to community resources to free up hospital beds for elective surgeries (see page 39, *Improve access to community care and home supports*).

Currently, private surgical clinics are allowed to perform only day surgeries with a maximum one-night stay, which limits the type and complexity of procedures they can offer. The same restrictions are similar across Canada. With the proposed change, BC would become the first province to allow three-day stays in private, for-profit surgical facilities.[23] Put simply, this move would sanction a private, for-profit hospital sector, whereas in BC today there is a relatively small number of private day surgery *clinics*. The College of Physicians and Surgeons of BC commented that:

> …we don't really have private hospitals in this province today, what we have are private facilities … But the minute you start saying well it's a three-day stay … it's got to look like a hospital which means you have acute care nurses, hospital pharmacists, RT, PT, OT, blood bank and transfusion services.[24]

With the proposed change, BC would become the first province to allow three-day stays in private, for-profit surgical facilities. Put simply, this move would sanction a private, for-profit hospital sector.

In a *Vancouver Sun* article, the College's registrar added: "When you think of hospitals, you think of 24-hour staff, security guards, meals and so on."[25] This shift will clearly require significant capital, potentially attracting multinational corporations and US hospital chains to the province. As well, the BC government's proposal would require a legislative amendment to change the legal status of hospitals in the province, which are currently required to operate as "non-profit institutions".[26]

Allowing three-day overnight stays in private facilities could significantly increase the number of surgeries contracted out to the for-profit sector. According to the BC Ministry of Health, in 2013/14, 70,599 scheduled (or elective) inpatient (overnight) surgical procedures were performed in the public system (in addition to 48,704 unscheduled or emergency inpatient surgeries). Of these elective procedures, 48,028 involved patients staying up to three days. By allowing up to three-day stays in private facilities, up to 68 per cent of elective surgeries in the province could be performed in the for-profit surgical sector in 2013/14.[27]

And although the *Future Directions* paper does not describe how the BC government will implement three-day overnight stays in private facilities, one regional health authority is already experimenting with new strategies to contract out day procedures. In April 2015, the Vancouver Island Health Authority announced plans to contract out up to 55,000 day procedures over five years to the for-profit surgical sector (3,000 to 4,000 day procedures and 5,500 to 7,000 endoscopies per

23 We informally surveyed provincial Colleges of Physicians and Surgeons by email and telephone to verify that three-day stays in private surgical facilities are not currently allowed anywhere in Canada.

24 Interview, College of Physicians and Surgeons of BC, 2015.

25 Fayerman, 2015a.

26 Hospital Act, [RSBC 1996] c. 200, s. 1

27 Ministry of Health and the Provincial Surgical Executive Committee, 2015, pp. 24, 37.

year)—a move that, within one health authority alone, could double the number of procedures performed in private, for-profit clinics in BC.[28]

This approach diverts attention and resources away from the public system and takes pressure off of Ministry of Health and health authority leaders to make better use of existing surgical capacity.

This plan for publicly funded private delivery will use the health authority's physicians and surgical booking system—measures that will partially address two problems associated with private sector delivery. First, the use of health authority physicians, rather than surgeons employed by the private facility, will address the problem of competition that often occurs when the public and private systems must compete for the same physicians. And secondly, using the same booking system means that patients who are waiting the longest and have the highest needs can be prioritized. However, fundamental issues remain, including the higher costs and possible volume guarantees often associated with for-profit delivery, and the competition over a limited pool of health human resources, such as nurses, that can lead to staffing shortages and longer waits in the public system. As well, there are significant opportunity costs with this approach; it diverts attention and resources away from the public system and takes pressure off of Ministry of Health and health authority leaders to make better use of existing surgical capacity and improve operating room efficiencies (see page 21, *Private, for-profit delivery destabilizes the public system*).

In the second half of the paper, we provide an extensive analysis of key public sector wait time solutions that can deliver cost savings, improve patient outcomes and ensure the sustainability of the public system in the long run. As we also know from Canadian and international experiences, there are significant problems associated with surgical delivery by the private, for-profit sector—problems we turn now to examine in detail.

28 In 2013/14, 5,503 publicly funded day procedures were performed in private facilities. Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 23; Vancouver Island Health Authority, 2015a; Harnett, 2015.

The problems with private, for-profit delivery of surgical services

DRAWING ON A LARGE BODY OF RESEARCH EVIDENCE, the Canadian Foundation for Healthcare Improvement concluded that private, for-profit health care delivery is not the solution to reducing wait times and improving the quality of surgical care.[29] Private sector delivery can, in fact, increase wait times in the public system.[30] This section summarizes some of this research, including evidence from many of the academics that have provided expert testimony in the Day case. Our focus is specifically on the problems associated with publicly funded, private for-profit surgical delivery, or contracting-out surgical procedures, not on private insurance or a parallel, private-pay health care system.

Private sector delivery can, in fact, increase wait times in the public system.

PRIVATE, FOR-PROFIT DELIVERY COSTS MORE

Private, for-profit providers are more expensive as a result of higher administrative costs, the requirement to return profits to investors, and additional costs associated with creating and enforcing new regulations for private providers.

The US evidence shows private, for-profit facilities have higher administrative costs due to more complex systems of billing and securing funds for capital expansion[31] and higher compensation rates for senior administrators.[32] Moreover, the very nature of *for-profit* delivery pushes costs upwards as investors require a profitable return. One study found that investors typically require 10–15 per cent return from for-profit facilities—a requirement that does not exist for public and

29 Canadian Foundation for Healthcare Improvement, 2005.

30 Donaldson and Currie, 2000; Canadian Foundation for Healthcare Improvement, 2004.

31 Himmelstein et al., 2014; see also Woodhandler et al., 2003. Higher administrative costs are often associated with the higher costs and complexities of billing multiple insurance providers within the US health care context.

32 Devereaux et al., 2002a, p. 1404.

non-profit facilities.[33] Another study found US for-profit hospitals are 20 per cent more expensive than hospitals operated by non-profit organizations.[34]

In order to deliver profitable returns and account for higher administrative costs, costs per procedure are often higher in the for-profit sector than in the public system. In Britain, the Department of Health acknowledged that procedures purchased from independent sector treatment centres (or private surgical centres) cost, on average, 11.2 per cent more than the National Health Service (NHS) equivalent in the public system, but costs could be even higher since these private sector contracts are subject to commercial confidentiality and have not been released publicly.[35]

Many jurisdictions have turned away from for-profit delivery of diagnostic imaging and surgical services because they are more expensive than the public sector.

In Canada, procedures and diagnostic imaging performed in for-profit clinics are more expensive than in public hospitals. In BC, the workers' compensation system (WorkSafeBC) often uses private clinics for expedited surgeries. A 2011 study published in *Health Policy* found that WorkSafeBC paid almost 375 per cent more for an expedited knee surgery in a private clinic ($3,222) than for a non-expedited surgery in a public hospital ($859).[36] In February 2016, it was revealed that Vancouver Island Health Authority is paying for-profit clinics nearly twice the per-scan price ($550) for MRIs than the cost to perform them in the public system ($300).[37] Many jurisdictions, in fact, have turned away from for-profit delivery of diagnostic imaging and surgical services because they are more expensive than the public sector. In Alberta, the government ended a contract with a Calgary for-profit clinic for publicly funded, private delivery of medical and surgical services because it was more expensive than the public sector.[38] The Calgary clinic also went bankrupt, leaving taxpayers on the hook for millions of dollars.[39] Similarly in 2011, the Vancouver Island Health Authority abandoned plans for private MRI delivery because it determined the public sector was more cost-effective.[40] At the time, it was estimated MRIs could be conducted in the public system for $250 each, while the private sector charged four times that rate.[41] In 2014, the Quebec government ended two contracts with private surgical centres—Rockland MD and the Eye Institute of the Laurentians—after it became clear that the per case cost was lower in the public system.[42] Since the public sector repatriated surgeries from the private Rockland MD clinic, the waitlist for day surgeries in the public system has decreased.[43]

The BC government's proposal to contract out up to three-day overnight stays would also require significant regulatory changes to ensure adequate oversight of private facilities performing more complex surgeries.[44] The College of Physicians and Surgeons of BC accredits private facilities; in order to receive accreditation, these facilities must adhere to the College's standards and undergo inspections. The current accreditation program, intended for private facilities offering day surgeries only, will require an overhaul to add heightened requirements for private facilities to offer up to three-day stays. As a result, the College's accreditation fees, charged on a cost-recovery basis to for-profit facilities, would increase. As the College acknowledges, these increased costs would

33 Ibid.
34 Devereaux et al., 2004.
35 House of Commons Health Committee, 2006, p. 37–38; Pollock and Godden, 2008; Player and Leys, 2008.
36 Koehoorn et al., 2011, p. 57.
37 Harnett, 2016.
38 Gibson & Clements, 2012.
39 Ibid.
40 Hunter, 2011.
41 Ibid.
42 Duchaine and Lacoursiere, 2014; Lacoursiere, 2014.
43 Archambault, 2016.
44 Fayerman, 2015a.

be passed on to government as for-profit facilities would increase their billing rate to the health authorities. As the College explains,

> …the more the health authorities contract these cases out, then the facilities have to pay for their services and they are going to reflect it in the cost to the health authorities, and part of the cost they have is the cost of accreditation. Quite clearly it's going to be passed on to both the public for private [pay] surgery but also onto the public in terms of the… costs [private facilities] are going to charge [health authorities].[45]

Rather than saving costs by maximizing and expanding public sector surgical capacity through operating room efficiencies and quality improvement initiatives, the public will be handed the bill to set up a new—and complex—regulatory framework to accredit and monitor private, for-profit facilities for up to three-day overnight stays. There is a significant opportunity cost when resources go towards regulating the private sector and managing contracts instead of into patient care and public sector innovation.

PRIVATE, FOR-PROFIT DELIVERY IS LOWER QUALITY AND LESS SAFE

For-profit facilities are associated with a higher risk of mortality compared with non-profit facilities.

Fewer skilled personnel per hospital bed are associated with higher hospital mortality rates.[46] To increase profits, private hospitals employ fewer highly skilled personnel per bed.[47] As a result, patient safety may be sacrificed in order to generate profits for investors. P.J. Devereaux's meta-analysis of studies comparing mortality rates for 26,000 for-profit and non-profit hospitals, serving 38 million patients in the US, concluded that "private for-profit ownership of hospitals, in comparison with private not-for-profit ownership, results in a higher risk of death for patients."[48] The authors raise concerns about the potential negative health outcomes if governments open the door to private, for-profit hospital care in Canada. In another meta-analysis of eight studies comparing the mortality between for-profit and non-profit hemodialysis facilities, the authors found for-profit facilities are associated with a higher risk of mortality compared with non-profit facilities, concluding that there are 2,500 excessive premature deaths in US for-profit dialysis centres each year.[49]

The British Medical Association, a vocal critic of health care privatization, found significant issues with the quality, safety and continuity of care in England's private surgical sector. Two-thirds of clinical directors surveyed across three specialty areas were aware of patients who had developed complications following treatment in private clinics and who required readmission to public hospitals[50]—not only a safety concern but an additional cost burden to the public system. Half of the clinical directors surveyed were "concerned about the general quality of care provided… particularly by… [private surgical centres]. Concerns centre[d] around the quality of specialist care provided by the treatment centres, the loss of continuity in medical provision and the lack of long term patient care."[51] Moreover, evaluating the quality of care provided by these private surgical centres in England has also been difficult due to the lack of comparable high-quality clinical outcomes data.[52]

45 Interview, College of Physicians and Surgeons of BC, 2015.
46 Devereaux et al., 2002a.
47 Ibid.
48 Devereaux et al., 2002a, p. 1399.
49 Devereaux et al., 2002b.
50 BMA Health Policy and Economic Research Unit, 2005.
51 Ibid., p. 4
52 King's Fund, 2009, p. 6.

In Canada, patient safety and quality concerns have emerged in Ontario's private, for-profit clinics. A *Toronto Star* investigation found significant problems, including:

- 13 per cent of private clinics in Ontario performing day procedures did not meet provincial inspection standards, including 3.6 per cent of private clinics that "failed inspections because of public safety concerns";[53]
- 12 clinics failed inspections (of 330 clinics inspected) and 33 clinics were given conditional passes, some of them even two or three times;[54] and
- at least nine patients developed serious infections, including meningitis, and 11 patients from three colonoscopy clinics acquired hepatitis C, yet the clinics did not fail inspections.[55]

This is a notable contrast to Ontario's 150 public hospitals that, since 2011, have never failed a review conducted by Accreditation Canada.[56]

To return a profit to investors, private facilities often cut corners to reduce costs, typically through lower staffing levels of skilled personnel.

At the time of writing, the College of Physicians and Surgeons of Ontario publicly posts a limited amount of information from their inspection reports on their website; meanwhile, at present the College of Physicians and Surgeons of BC does not post inspection results, but it has indicated it is moving towards a similar public reporting approach.[57]

Surgical quality improvement programs are widely recognized ways to ensure high quality care and identify areas for improvement. Important efforts are under way in BC and across Canada to implement programs in the public system. For example, the American College of Surgeon's National Surgical Quality Improvement Program (NSQIP) is an internationally respected program to measure and improve the quality of surgical care by, among other things, reducing surgical site infections and helping hospitals measure and understand their outcomes. It has been implemented in 25 public hospitals in BC and 17 in Ontario.[58] However, no private surgical clinics in BC currently participate in NSQIP, and there are no immediate plans for them to participate because of the considerable administrative infrastructure and expertise required to do so.[59]

The Canadian and international evidence shows clearly that private, for-profit health care delivery is generally less safe and lower quality care. To return a profit to investors, private facilities often cut corners to reduce costs, typically through lower staffing levels of skilled personnel.

PRIVATE, FOR-PROFIT DELIVERY CAN INCREASE THE PREVALENCE OF INAPPROPRIATE SURGERIES

When surgical care is provided by a for-profit clinic, medical decision-making—especially for elective surgery—is much more susceptible to conflict of interest leading to inappropriate surgical intervention. Surgeries are inappropriate if they do not provide a health benefit to the patient, are risky or result in deterioration in a patient's health status. When contracting out surgical services,

53 Boyle, 2014b.
54 Ibid.
55 Boyle, 2014a.
56 Boyle, 2014b.
57 Interview, College of Physicians and Surgeons of BC, 2015.
58 Surgical Quality Action Network, 2014; Health Quality Ontario, n.d.
59 Interview, College of Physicians and Surgeons of BC, 2015.

governments may face increased costs because for-profit providers have a financial incentive to selectively offer and perform more profitable procedures even if they are clinically inappropriate.[60]

The question of appropriate surgical intervention remains a significant issue within the public system as well (see page 36, *Reduce inappropriate surgeries*). But the evidence from the US focuses attention specifically on the financial incentive for private clinics to prefer healthier patients and simpler, lower cost surgeries in order to increase their profit margin—a practice referred to as "cream skimming."[61] US studies have found a significant relationship between physician ownership of surgery centres and increased use of surgeries to treat patients.[62] In one US study, physician board directors of surgery centres "steered patients from hospitals to their affiliate [private surgery centres]."[63] Physician board membership, on average, "led to a 27 per cent increase in a physician's procedure volume and a 16 per cent increase in a physician's colonoscopy volume."[64]

With the proposal for up to three-day stays in private facilities, it is possible that routine and lower complexity surgeries may move to the private sector. But without "deeply engaging in a conversation about appropriateness" (in the Ministry of Health and Provincial Surgical Executive Committee's own words),[65] costs of inappropriate surgeries will be borne by the public while private clinics profit. In other words, the contracting out of simpler, routine procedures may undermine the important work around appropriateness that needs to occur. This is especially the case when physicians are owners or investors and have a financial stake in driving the surgical volume of more profitable procedures at these facilities.

One of the significant obstacles to addressing inappropriate surgeries in BC for-profit clinics is the fact that their operations are shrouded in secrecy.

One of the significant obstacles to addressing inappropriate surgeries in BC for-profit clinics is the fact that their operations are shrouded in secrecy. As noted earlier in this report, a 2012 BC government audit uncovered evidence of extra-billing at Brian Day's clinics, but the clinics refused to fully disclose their financial statements, ledgers and contractual arrangements with physicians.[66] And so, not surprisingly, there are no reporting systems in place to address the issue of inappropriate and unnecessary surgeries occurring in the for-profit sector.

PRIVATE, FOR-PROFIT DELIVERY DESTABILIZES THE PUBLIC SYSTEM

From 2010 to 2013, BC relied primarily on pay-for-performance incentives and activity-based funding to reduce wait times.[67] As part of this strategy, health authorities negotiated short-term contracts with private, for-profit clinics. As the Ministry of Health and Provincial Surgical Executive Committee's policy paper acknowledges, these contracts "can create issues in terms of insufficient lead time for surgeon scheduling and lack of sustainability for the private surgery centres."[68] The Ministry and Provincial Surgical Executive Committee unfortunately appear to be more concerned about creating stability for the private surgical sector than the risks and challenges it creates for the public system.

If the BC government's approach to contracting out three-day overnight stays allows for the private staffing of these for-profit facilities, the public and private sectors will be competing over

60 See Horwitz, 2005.
61 Kreindler, 2010, p. 16; Gonzalez, 2004.
62 Hollingsworth et al., 2009; Mitchell, 2010; Yee, 2011.
63 Yee, 2011, p. 904.
64 Ibid.
65 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 9.
66 Ministry of Health, 2012.
67 Ministry of Health and the Provincial Surgical Executive Committee, 2015, pp. 33–34.
68 Ibid., p. 36.

the same limited pool of health human resources. This competition often occurs when the private system offers incentives to attract health care workers from the public system, leading to staffing shortages and longer waits in the public system.[69] Staffing and overall costs may increase in order to maintain the same service level in the public system, putting the long-term sustainability of the public system in question as it becomes more difficult to contain costs.

As noted earlier, the BC government's proposal for up to three-day overnight stays in private surgical facilities will lead to the growth of a for-profit hospital sector in BC.[70] A for-profit hospital sector likely means larger corporate international investors with the ability to raise the capital required to build and operate private hospitals. The proposal to contract out significantly increases the risk of multinational corporations, specifically US hospital chains, getting a foothold in this sector. Once entrenched in the health care system, they are likely to form industry associations to lobby for more contracts and oppose more stringent regulations.[71]

A for-profit hospital sector likely means larger corporate international investors with the ability to raise the capital required to build and operate private hospitals.

To enter the market, these corporations will need a guaranteed source of revenue and profit. In for-profit health care delivery, one of the primary ways to accomplish this is by "cream skimming" healthier patients and less complex procedures. Consequently, this can destabilize the public system as the efficiencies and cost savings that derive from simpler, more predictable surgeries become profits for shareholders in the private facilities rather than these savings captured and used by the public system to improve access and reduce costs. Over time, the reliance on for-profit providers means that the public system has less ability to negotiate prices with private clinics because they may lose the capacity to provide these services publicly.

Doctors of BC affirms this point in response to the proposal to contract out up to three-day stays in the private sector:

> It is also important to ensure that use of private facilities or centralization of services doesn't destabilize hospitals. Simply taking the "easy" procedures out of hospitals could prove detrimental to the current balance of procedures in hospital settings.[72]

Their concern is borne out by the British experience with private surgical centres. The British Medical Association found "distorted case-mix, whereby the treatment centre has 'cherry picked' cases, [and] the loss of continuity of patient care and control of patient pathways."[73] As we know from the BC government's experience with Brian Day's clinics, the private sector's tendency to maintain proprietary control over information poses significant barriers for planning a patient-focused health care system with integrated data management and outcomes reporting.

69 Donaldson and Currie, 2000; Canadian Foundation for Healthcare Improvement, 2005.
70 Fayerman, 2015a.
71 See Miller and Mor, 2008; Jansen, 2009, p. 59.
72 Doctors of BC, 2015, p. 14.
73 BMA Health Policy and Economic Research Unit, 2005, p. 4

Why not use existing public sector surgical capacity?

THERE IS STRONG INTERNATIONAL EVIDENCE to suggest that surgical wait times can be reduced by using existing surgical capacity more efficiently.[74] In the *Future Directions* report, the BC Ministry of Health and the Provincial Surgical Executive Committee acknowledge that existing public sector infrastructure is underutilized and there is considerable room to use resources more efficiently:

> At the local level it is recognized that existing operating room capacity is not used in the most efficient and effective way to optimize access to surgical services nor are surgical services organized in metro areas, with multiple hospital resources, in a manner that would drive quality, efficiency and through-put.[75]

This assessment is confirmed by Doctors of BC in its response to the *Future Directions* report:

> …[W]e can and should make better use of existing surgical infrastructure. Operating rooms are currently underutilized due to staff or operational funding shortages, surgeons are underemployed, and waitlists are getting longer. Surgical infrastructure and resources need to be closely examined and efforts made to support the effective and efficient use of surgical facilities.…Surgical suites sit unused throughout the day and night and it is possible that currently underemployed surgeons would be willing to work evenings and/or weekends to facilitate timely access to surgical services.[76]

In fact, 18 per cent of operating rooms in public hospitals are not regularly staffed primarily because of inadequate funding,[77] and no operating rooms in the province have extended hours. In the summer months, 23 per cent of operating room daytime capacity is closed.[78]

Eighteen per cent of operating rooms in public hospitals are not regularly staffed primarily because of inadequate funding, and no operating rooms in the province have extended hours.

74 Rachlis, 2005; Kreindler, 2010.
75 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 43.
76 Doctors of BC, 2015, p. 14.
77 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 36.
78 Ibid.

Making full use of existing public hospitals should be a top priority. It's puzzling that the *Future Directions* report includes no provincial strategy for how to better utilize the existing capacity in the public system. At the very minimum, the report should have recommended a cost-benefit analysis to examine the evidence and relative merits of using existing public infrastructure as opposed to contracting-out services to private, for-profit providers.

Yet it appears that one health authority is already experimenting with strategies to create more stability and a greater role for the private sector. In April 2015, the Vancouver Island Health Authority (VIHA) announced plans to contract out up to 55,000 day procedures over five years to the private sector, without conducting a cost-benefit analysis. In a July 2015 letter, Norm Peters, executive director of Surgical Services at VIHA, noted that their "initial evaluation indicates that the cost of providing the surgeries in a [private] non-hospital surgical centre is comparable to Island Health's cost," yet a detailed comparison of the costs of private versus public delivery was not provided.[79] Peters added that "it is difficult to do a direct comparison of the full cost" and that if all the 'back end' costs were included, public sector costs would likely be much higher.[80] This contradicts the international evidence showing that private, for-profit delivery is more costly. Without evidence of a cost-benefit analysis, it remains unclear how VIHA arrived at the conclusion that private sector delivery is comparable or cheaper than the public system—especially when it was revealed that VIHA is paying private clinics nearly twice the per-scan price for MRIs than it costs to perform them in the public system.[81]

The Vancouver Island Health Authority plans to contract out up to 55,000 day procedures over five years to the private sector, without conducting a cost-benefit analysis.

A five-year contract to provide up to 55,000 surgeries has now been signed with Surgical Centres Inc.—a for-profit provider with clinics across Canada. The RFP states clearly that Surgical Centres Inc. can also provide non-insured services on a cost-recovery basis and contract with other governments and governmental agencies (e.g. WorkSafeBC).[82] In other words, this model of contracting out provides considerable financial stability for Surgical Centres Inc.

Beyond the fact that there is no evidence that a cost-benefit analysis was conducted, the issue of "volume guarantees" also remains a concern. With private sector contracts, jurisdictions often guarantee payment to private providers in order to get them to enter the market—regardless of whether that volume is met. This may be the case in the contract between VIHA and Surgical Centres Inc. to complete 42,500 to 55,000 surgeries over the next five years.[83] In England, as a result of volume guarantees, close to £500 million of public funds were paid to private surgery centres for procedures that never occurred.[84] In addition, the government had to buy back some of the private centres at the end of the contracts.[85]

We also know that relying on private sector delivery diverts attention and resources away from evidence-based strategies to make better use of existing surgical capacity and improve operating room efficiencies in the public system (see page 28, *Maximize surgical capacity and optimize*

79 Letter from Norm Peters of Vancouver Island Health Authority to Lois Jarvis of Citizens for Quality Health Care, July 27, 2015. Letter available from the authors upon request.

80 Ibid.

81 Harnett, 2016.

82 Vancouver Island Health Authority, 2015b, p. 6. The RFP states that, in the addition to providing services for Vancouver Island Health Authority, the contractor can offer "procedures that involve other governments, government agencies, other public or private sector organizations, or non-insured services for private pay."

83 Without seeing the final contract, we do not know whether a volume guarantee was agreed to. The RFP states that "it is important for Proponents to note that there are no minimum volumes, funding or exclusivity guarantees except to the extent as may be expressly agreed upon by Island Health and a successful Proponent(s)." Vancouver Island Health Authority, 2015b, p. 4.

84 Slater and Beckford, 2011.

85 Ibid.

operating room performance). There is less pressure on the public system to increase surgical volume through the more efficient use of existing resources when you are buying capacity from the private sector. VIHA's move to contract out may also create longer waits in the public system because it will be more difficult to recruit and retain the necessary nursing staff for public hospitals if they are working in the private system.[86]

The VIHA model, at this point, focuses only on day procedures in one health authority, and so it is less radical than the BC government's proposal for up to three-day overnight stays in private facilities. Although it remains to be seen what exact form the BC government proposal for three-day overnight stays will take, the College of Physicians and Surgeons of BC is clear that it will require a shift from private clinics to private hospitals.[87] Creating a private hospital sector in BC will require larger corporate investors who will, no doubt, expect financial guarantees before they enter the market. Yet we know from our earlier discussion of the international evidence that large corporate investor-owned hospitals are also associated with lower quality care and higher costs.[88]

Using existing surgical capacity is one of many strategies requiring leadership from the provincial government. We now turn to examine key features of successful public sector innovations that are highly effective at reducing wait times and improving patient care in the long term.

86 Nursing shortages, for example, remain a significant concern. In late 2015, there was a reported shortage of about 30 operating room nurses at Vancouver General Hospital (see Fayerman, 2015b).

87 Fayerman, 2015a; Interview, College of Physicians and Surgeons of BC, 2015.

88 Kreindler, 2010, p. 12.

Key features of successful public sector innovations

IN THIS SECTION, WE DISCUSS SIX KEY FEATURES of successful public sector innovations that have improved timely access to appropriate elective surgical care and enhanced the patient experience while also delivering safe, high quality care. In our discussion, we highlight best practices drawn from Canadian and international public sector innovations to develop recommendations for redesigning surgical services in BC.

In BC, some highly successful and cost-effective initiatives have been discontinued or cut back due to a lack of health authority and provincial support.

Specifically, we look at practices in Scotland and Saskatchewan, and local improvement initiatives in BC. Scotland is a global leader in public sector innovation, having made long-term wait time reductions a high priority for the last 20 years. We also look at innovative elements of the Saskatchewan Surgical Initiative—a four-year program (2010–2014) to reduce surgery wait times to three months from the surgery booking to its completion (referred to as Wait 2; see Table 1). However, the four-year initiative ended in 2014 and the lack of sustained commitment has meant wait times are again getting longer.[89] In addition, we examine pilot improvement initiatives in BC, where there are some very promising new regional initiatives as well as longstanding, highly successful and cost-effective initiatives that have been discontinued or cut back due to a lack of health authority and provincial support.

HOW DOES BC COMPARE?

Wait times across the surgical patient journey can be split into four different waiting periods, as shown in Table 1. In BC, only Wait 2—surgery booking to its completion—is reported by the provincial government through the Surgical Patient Registry, and therefore, the following comparisons refer to this waiting period. Compared to Saskatchewan, BC continues to lag behind in meeting Canada's knee replacement benchmark of 26 weeks. In Saskatchewan in 2015, 99 per cent of knee replacement patients received surgery within 26 weeks of booking the procedure. In BC, only 47 per cent of knee replacement patients received surgery within this time period. In Scotland in 2015, 90 per cent of all trauma and orthopaedic surgery patients (the closest comparison available) were treated within 12 weeks.[90]

89 McKinnon, 2015.

90 This figure includes inpatient and outpatient day cases. Authors' calculation based on data obtained in March 2016 from a custom request to NHS Scotland's Information Services Division. Data available from the authors upon request.

SCOTLAND: LEADING THE WAY IN PUBLIC SECTOR WAIT TIME SOLUTIONS

With nearly 5.3 million people, Scotland is slightly larger than British Columbia. Like Canada, Scotland has a publicly funded, single-payer health care system, providing universal access to residents. Scotland's central government oversees the delivery of public health services by regional health boards, much like BC's government does with the province's health authorities. BC can learn a lot from Scotland's ambitious work to significantly reduce wait times and improve health outcomes over the past two decades.

Canada's Wait Time Alliance notes that "As seen in many other countries with universal health systems, it is indeed possible to have timely access to medical care—long waits are not an unavoidable price to pay nor are they tolerated by their citizenry."[91] In fact, the Wait Time Alliance identifies Scotland as a global leader in developing long-term public sector wait-time solutions while also improving the quality of care:

> In addition to providing timely access, [Scotland has] been successful in improving other dimensions of quality of care (e.g., significantly reducing levels of hospital-acquired infections, reducing the level of inappropriate care), and performance in all of these dimensions is being tracked through the measurement and reporting of performance targets for use by patients, providers, and system managers alike.[92]

BC can learn a lot from Scotland's ambitious work to significantly reduce wait times and improve health outcomes.

In 2011, the Scottish government introduced the 18 Weeks Referral to Treatment Standard to ensure surgical and medical patients receive treatment within 18 weeks from referral by family doctor (GP) to a specialist to the completion of their surgery, including diagnostic testing and specialist consultation (i.e., 18 weeks includes Waits 1, 2, and 3; see Table 1).[93] This is far different from the current situation in BC where no information is publicly reported on the time it takes from GP referral to specialist consultation (Wait 1), and where, for procedures like knee surgeries, for example, more than 50 per cent wait longer than 26 weeks.[94]

How did Scotland do it? The four integrated strategies of the 18 Weeks Referral to Treatment Standard include:

- **A SYSTEM REDESIGN AND TRANSFORMATION STRATEGY,** focusing on improving referral and diagnostic pathways, centralized intake and pooled referrals, treating day surgery as the norm, operating room efficiencies, patient care pathways to ensure appropriateness and consistency of care, and Quality and Efficiency Support Teams ("improvement teams") working with every health board to implement initiatives and achieve outcomes through a strong focus on clinical engagement and leadership;
- **AN INFORMATION STRATEGY** to accurately track and report on the whole patient journey from referral to treatment;
- **A PLANNING STRATEGY,** to balance elective and emergency care and focus on capacity and workforce planning to address the mismatch between surgical demand and existing capacity;

91 Wait Time Alliance, 2014, p. 2.

92 Ibid.

93 Within the 18 Weeks Referral to Treatment Standard, there is a guarantee that patients receive day case or inpatient treatment within 12 weeks of agreement to treat. However, the 18 weeks standard may not be possible for all patients, especially in cases when patients require significant diagnostic testing or when treatment is not clinically appropriate within this time period.

94 See Table 2; Canadian Institute for Health Information, 2016.

- **A PERFORMANCE MANAGEMENT STRATEGY** to ensure responsibility for delivering the 18 Weeks Referral to Treatment Standard lies with the Scottish government's national-level Health Delivery Directorate and is achieved through ongoing engagement and coordination with regional NHS health boards.[95]

Scotland began addressing the problem of wait times 20 years ago. At that time, the central government did not even know how many people were waiting or how to manage waitlists but it began moving forward year after year.[96] In January 2011, 82 per cent of patients were treated within 18 weeks, and upon implementation of the 18 Weeks Referral to Treatment Standard in December 2011, this rose to 92 per cent of patients. By June 2015, due to some struggling health boards, this had slipped to 88 per cent of patients meeting the standard.[97] Recognizing some of the challenges local boards were facing, the central government provided leadership by deploying NHS resources to particular boards (such as health administration expertise to improve clinical governance), in order to support boards in meeting the 18 weeks standard. In some cases, NHS boards make minimal use of the private sector—and only in the short term—when they are unable to meet their wait time guarantees by treating patients in the public system. The Scottish government's response in these situations is consistently to find ways to increase capacity in the public system and avoid entrenching its reliance on private providers. Put simply, the Scottish government does not sit back and watch the health boards slip; rather, it provides the leadership needed to support these NHS boards meet their targets.

The Scottish government's response is consistently to find ways to increase capacity in the public system and avoid entrenching its reliance on private providers.

The long-term trends for specialist (surgeon) consultation to inpatient or day treatment completed (Wait 2) are also impressive, especially in reducing waits for patients who are waiting the longest (i.e., those at the 90th percentile of the waitlist). In 1998, the median patient wait (inpatient and day case) was 35 days and the wait for patients in the 90th percentile was 169 days. Remarkably, by 2011, median patient waits had dropped to 24 days and waits for patients in the 90th percentile had dropped to 61 days.[98]

Scotland's journey from long waits to improved access is nothing short of remarkable—and the country has done it with a very limited use of the private sector. As Mike Lyon of the Scottish government notes, the private sector is "not part of the permanent provision" of surgical services.[99] Rather, central government leadership and coordination has been necessary to drive and sustain system-wide improvement.

MAXIMIZE SURGICAL CAPACITY AND OPTIMIZE OPERATING ROOM PERFORMANCE

Maximizing surgical capacity and optimizing operating room performance can lead to significant wait time reductions and cost efficiencies. Specific strategies include optimizing scheduling and reducing downtime. For example, operating rooms can operate on a staggered schedule if they use two rooms, allowing for surgical teams to "swing" between rooms as their patients are prepared for surgery by other team members. Efforts to maximize operating room time may also include moving less complex procedures out of hospital operating rooms into specialized outpatient

95 Scottish Government, 2008.
96 Interview, Richard Copland, Head of Access, Workforce, and Performance Directorate, Scottish Government, 2015.
97 Information Services Division, 2011, 2015a.
98 Smith and Sutton, 2013, p. 320.
99 Interview, Mike Lyon, senior advisor to the Scottish Government, Healthcare Access and Sustainability, 2015.

procedure rooms, scheduling more complex cases at the end of the day (which reduces delays and cancellations) and investing in more equipment sets to enable surgeons to move from case to case without waiting for cleaning. Standardizing surgical procedures (including equipment sets used) and clinical practices can reduce variation and increase operating room throughput, meaning more surgeries can be completed in the same amount of time with a relatively small investment of money. Furthermore, additional capacity in the public system can be created by extending operating room hours.

The Saskatchewan Surgical Initiative increased surgical capacity by extending and increasing the efficiency of operating room time by using "mirrored" operating rooms (surgical teams swinging between two operating rooms). Ron Epp of the Saskatchewan Ministry of Health explains:

> At the onset, yes, we did create additional capacity within our system to do more surgeries to work down our backlog. Some of the strategies used were extending the hours of the operating rooms, [and] creating a policy that required surgeons to return unused operating room time within a week, so it could be reallocated.[100]

However, when the Saskatchewan Surgical Initiative was introduced in 2010, the Ministry not only took steps to increase surgical capacity in the public system, it also contracted with private, for-profit clinics to perform day surgeries in three areas (dental surgeries and knee and shoulder arthroscopies) and CT scans for patients on the public waitlist. Since the end of the Saskatchewan Surgical Initiative in 2014, the province appears to be pursuing greater private sector delivery of day surgeries and diagnostic testing and is less focused on increasing public sector capacity. Yet, the international research clearly shows that increasing public sector capacity, rather than contracting out, has the greatest potential to reduce waits in the long run.[101]

The international research clearly shows that increasing public sector capacity, rather than contracting out, has the greatest potential to reduce waits in the long run.

In contrast, in Scotland the government has been focused over the long term on increasing surgical capacity within the public system by adding operating rooms, improving throughput efficiency and moving procedures from an inpatient, overnight stay environment to day surgeries. Scotland's success comes from a mix of additional resources together with using existing resources more effectively and efficiently.[102]

Interestingly, some very innovative operating room efficiency programs have been successfully piloted in public hospitals here in BC, yet they do not receive serious consideration—or even a mention—in *Future Directions*. Our province's history of operating room performance and quality improvement initiatives should be recognized, supported and expanded across the province.

Richmond Hip and Knee Reconstruction Project

The CCPA's 2007 report *Why Wait?* featured the Richmond Hip and Knee Reconstruction Project,[103] which brought median wait times for hip and knee replacement surgery down by 75 per cent, from 20 months to five months. The project required investment in a second operating room so surgeons could swing between rooms, allowing the teams to complete eight joint replacements or reconstructions per day instead of six. The group of surgeons moved from using nine different types of prosthetic devices between them to using the same one, making work smoother for

100 Interview, Ron Epp, director, Strategic Priorities, Saskatchewan Ministry of Health, 2015.
101 Kreindler, 2010, p. 12; Rachlis, 2005.
102 Interview, Jim Crombie, chief officer, Acute Hospital Services, Lothian Health Board, NHS Scotland, 2015.
103 Priest et al., 2007, pp. 14–15.

the surgical teams and saving money. "We went from doing 200 cases/year to, at the best, around 700 cases/year. All of a sudden your wait time is really dramatically improved," orthopedic surgeon Dr. Ken Hughes noted.

The Richmond project is particularly noteworthy because it achieved these efficiencies safely while performing both lower-complexity and higher-complexity surgeries, whereas the UBC Centre for Surgical Innovation—highlighted in *Future Directions*—started only with lower-complexity surgeries but now performs more complex cases after learning from the Richmond model.[104]

Actively managing inpatient beds was another key feature of the Richmond initiative, which led to improved patient flow and fewer cancellations. Project co-lead Cindy Roberts worked collaboratively with physicians and health care workers to improve clinical governance and actively manage available beds (referred to as bed mapping). For example, surgeons would often delay discharging patients in order to hold a bed for an upcoming surgery, which would lead to cancelled surgeries for other patients due to bed shortages. Inefficient and costly practices like this were addressed through bed mapping and an active, collaborative approach to clinical governance.

If BC is to become a high performing health care system, there is a fundamental need for a sustained commitment to quality improvement and efficiency from the Ministry of Health leadership on down.

Hughes and Roberts even created a toolkit—the Arthroplasty Plan—to help other hospitals implement the quality and efficiency improvement model they had developed. Despite the success, Vancouver Coastal Health Authority (VCHA) put a stop to the Richmond initiative two years ago, and the toolkit sits unused. Hughes laments that wait times have since increased and operating room efficiencies have been lost:

> Our wait times now are about eight months for surgery. They were all [less than] six months. Why? We lost a significant amount of operating room time … If you take away that throughput efficiency, it takes you more days to get it done. You don't throw away improvement. … You have to sustain it.[105]

Hughes calculates that the health authority could be completing more cases and saving money by using this more efficient model. Why was the project stopped? He points to the lack of leadership and engagement with this project:

> [We weren't] even involved in the discussion to put it on hold, or as it looks and appears to be, terminated. It's just mind-boggling…. It brings up one of the issues of sustainability of quality improvement projects, and that's a really big issue. If you have an efficient [model] and it takes such a significant amount of time to develop that model, to go away from it is hard to explain.[106]

Hughes went on to explain that the senior management executives who championed the innovation in the first place have moved on and there was no one left in the senior management team who had supported the initiative in the beginning.

Terminating an efficient model with such clear benefits comes at a significant cost to the public system. As Hughes points out, if BC is to become a high performing health care system, like Utah's non-profit Intermountain Health, there is a fundamental need for a sustained commitment to quality improvement and efficiency from the Ministry of Health leadership on down:

> We would not have a problem … if there was a commitment to the process … It goes back to Intermountain [in Utah] … If this works, we're going to do it this way, and the

104 Interview, Dr. Ken Hughes, orthopedic surgeon and Provincial Executive Surgical Committee member, 2015.
105 Ibid.
106 Ibid.

leadership should have been from [the Ministry of Health] all the way down [to mandate that this approach be implemented province-wide]. There's no reason why we have 28 sites [in BC] that are not doing it as efficiently as that.[107]

Mount Saint Joseph Hospital Cataract and Corneal Transplant Unit

The CCPA's 2007 *Why Wait?* report also featured the Mount Saint Joseph Hospital Cataract and Corneal Transplant Unit, which, unlike the Richmond initiative, continues to operate. At Vancouver's Mount Saint Joseph Hospital, a team of 17 ophthalmologists perform 9,000 total surgeries a year in three specialized procedure rooms, not in the hospital's main operating rooms. They perform more than 6,000 cataract procedures each year, more than any other hospital in the province.

Reflecting on progress since the 2007 *Why Wait?* report, head ophthalmologist Dr. Pierre Faber notes that changes have been "a little more incremental, but they are definitely [in] the right direction."[108] Waits have been further reduced at Mount Saint Joseph, with the average wait time for cataract and corneal transplant surgery at eight weeks, down from 12 to 16 weeks in 2007. They now perform up to 21 cases per day per procedure room (across three rooms), up from 12 to 17 a day in 2007. Key efficiency strategies include continuing to reduce downtime by starting surgeries on time, investing in multiple equipment sets so time is not lost for sterilization and standardizing nurses' pre- and post-operative engagement with patients. The program also saves money by using nurses trained to administer low levels of sedation rather than anesthetists.

Key efficiency strategies include starting surgeries on time, investing in multiple equipment sets and standardizing nurses' pre- and post-operative engagement with patients.

Another success has been moving some cataract surgeries from Richmond Hospital into Mount Saint Joseph's specialized procedure rooms one day each month. This move has freed up one Richmond operating room for other surgeries. "It costs way more to do [cataract surgeries] in the operating room," Faber notes.

Still, Faber points out that more could be done by moving all cataract surgeries in the health authority to one site. This would facilitate a central intake and even create greater region-wide efficiencies—meaning that more cases could be completed for the same amount of money.

Once again the issue is provincial leadership and the need for a provincial plan to maximize public sector surgical capacity and optimize operating room performance across the province. Implementing and sustaining improvement initiatives across surgical specialities, using innovative models such as those piloted at Richmond and Mount Saint Joseph hospitals, will reduce wait times and costs. Additionally, since surgical capacity in the public system remains underutilized, operating room funding and hours could be enhanced to provide greater capacity to work down the backlog and increase public sector capacity in the long run.

ACTIVELY MANAGE WAITLISTS THROUGH CENTRAL INTAKE AND POOLED REFERRALS

Active waitlist management is key to reducing wait times. It requires minimizing the number of waitlists, equalizing the size of waitlists between surgeons within each surgical specialty and regularly auditing the waitlists. Currently in BC, GPs refer patients to individual surgeons who

107 Ibid.
108 Interview, Dr. Pierre Faber, ophthalmologist, 2015.

each keep their own waitlists for consultations and surgeries. There is no centralized management or oversight of these waitlists by hospitals or health authorities.

In Scotland, patients are referred from their GP to a surgical specialty group at the hospital, rather than to an individual surgeon as is the case in BC. In technical terms, this practice has two aspects: central intake and pooling referrals. How does it work? A patient's GP makes a referral to a surgical specialty group (a group of surgeons); the referral is then triaged to the surgeon with the shortest wait and, based on the condition, the surgeon with the most appropriate clinical expertise to treat the patient. Central intake and pooling referrals together minimize the number of queues and eliminates the variation between surgeons by balancing the workload and ensuring every surgeon has consistent work. Put simply, this practice is intended to significantly reduce the long waits often common among senior physicians and ensure that equally qualified younger surgeons are able to build their practice. In Scotland, central intake and pooled referral have been key to the country's success at reducing waits.

Central intake and pooling have fostered greater trust and collegiality as well as a stronger shared commitment to improve patient care and access.

Currently in Saskatchewan, there are 18 specialist groups using central intake and pooling, comprising 110 of 759 specialists who could be pooling—or about 14 per cent of the total number of specialists in the province.[109] The Saskatoon urology group pioneered this work in Saskatchewan. Their administrative team receives referrals from GPs and, based on the issue, staff determine who within the group can most appropriately provide care and then assign that patient to the appropriate physician with the shortest wait time. After administrative staff triage patient referrals, all referrals are reviewed by a urologist to determine the urgency of the referral.[110] In Saskatchewan, there has been generally a 50 per cent reduction in waits within groups that have adopted central intake and pooling.[111] The implementation of central intake and pooled referrals, however, does not prevent patients from seeing their preferred specialist.[112]

Dr. Kishore Visvanathan, who currently leads the quality improvement initiative at Saskatoon Urology Associates, explains that a high degree of trust and collegiality among members of the practice has been crucial to implementing central intake and pooling within their group, ultimately improving access and reducing waits. Although they practise within a fee-for-service model with shared administrative staff, they pool their income and split it equally, similar to an alternate payment plan. With this arrangement, Visvanathan notes, there is no incentive for members of the group to hoard referrals or maintain long waitlists. The most common concern expressed among specialists is that central intake and pooling will reduce their work and incomes. In fact, the Saskatoon urology group has found the opposite: there is plenty of work for everyone. Central intake and pooling have fostered greater trust and collegiality within the group as well as a stronger shared commitment to improve patient care and access.

The Saskatchewan Ministry of Health is continuing to work with specialty groups to increase adoption of this practice, and it has gone one step further to support specialty groups through a provincial central intake for specialists who are not in the same office together with shared administrative staff.

In Scotland and Saskatchewan, there is strong evidence that central intake and pooling referrals reduce waits. But these practices are also most effective when surgical lists are actively managed.

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109 Interview, Ron Epp, director, Strategic Priorities, Saskatchewan Ministry of Health, 2015.

110 Interview, Dr. Kishore Visvanathan, urologist, 2015. Dr. Visvanathan notes that some specialist groups' pooled referral systems do not include review by the physician, and this has been a specific concern raised by some referring GPs as they are not confident non-medical staff can appropriately assess referrals.

111 Interview, Ron Epp, director, Strategic Priorities, Saskatchewan Ministry of Health, 2015.However, wait time reductions depend on the amount of capacity within that specialty group and the wait time variations among surgeons in that group prior to adoption of central intake and pooling.

112 Interview, Dr. Kishore Visvanathan, urologist, 2015.

Health authority or hospital administrative staff regularly audit lists to ensure patients on the list are actually waiting for surgery. Cindy Roberts, a former health system administrator, adopted this practice at Richmond Hospital in BC, noting that surgeons' offices often did not have time to audit their lists and, as a result, there was considerable variation in how waitlists were managed by different surgeons.[113]

In Saskatchewan, there have been efforts for the health regions and Ministry of Health to actively manage waitlists to ensure only patients who want surgery are on the waitlists. With the introduction of the Saskatchewan Surgical Registry in 2004, surgical waitlists were cleaned up, removing those patients that no longer wanted surgery. "Once we cleaned that up," noted Ron Epp, a Ministry of Health director, "we hived…almost 20 per cent or more of patients off of our waitlists."[114] The provincial policy to book an elective surgery now requires that a signed patient consent form be submitted with the surgical booking form. Elective surgeries are not booked without a signed consent form. In BC, important efforts have been underway to clean up waitlists by implementing patient prioritization coding, linking a patient's diagnosis and clinical condition to a maximum wait time target. This initiative was launched in 2010, with a review of the prioritization codes in 2014 and updated codes implemented in fall 2015. In BC as well, the Provincial Surgical Executive Committee is examining a standardized provincial electronic surgical booking solution to link surgeons' offices to hospital operating room booking systems. This will provide the waitlist data electronically, enabling the development of improved waitlist management policies.[115]

Asked about the barriers to implementing central intake and pooled referrals, both Ron Epp and Cindy Roberts talked about the concern of physicians—working as self-employed contracted providers within the fee-for-service payment system—that giving over control of their waitlists to the health authority will negatively impact their income and practice. This was particularly true among older physicians; younger physicians seem to be much more open to pooled referrals. In Scotland, the surgeons are not reimbursed through a fee-for-service payment system. They work directly for a regional health authority, which appears to have made the implementation of central intake and pooled referral much easier.

While the BC Ministry of Health and regional health authorities are beginning to provide the support necessary for active waitlist management and surgical patient prioritization, more provincial leadership is needed.

In BC, it is still common practice for a GP to refer to an individual surgeon. While there are some specialty groups in some communities where patients can be referred to the "first available" surgeon (or can choose to wait longer for their preferred surgeon), it is not standard practice. This is largely due to the fact that in BC, unlike in both Saskatchewan and Scotland, there is no provincial level coordination: that is, Ministry of Health staff have not been tasked with responsibility for identifying successful local central intake and pooling initiatives, documenting the reduction in wait times and then finding ways to support the replication of these initiatives in other surgical specialties and province-wide.

While the BC Ministry of Health and regional health authorities are beginning to provide the support necessary for active waitlist management and surgical patient prioritization, more provincial leadership is needed to ensure the broad implementation of central intake and pooled referrals across communities and surgical specialty groups. This would include the province seriously considering shifting away from fee-for-service payment models to a compensation model that better aligns physicians' accountability with strategies for implementing central intake and pooled referrals locally and regionally.[116]

113 Interview, Cindy Roberts, former health authority administrator, 2015.

114 Interview, Ron Epp, director, Strategic Priorities, Saskatchewan Ministry of Health, 2015.

115 Interview, Dr. Ken Hughes, orthopedic surgeon and Provincial Surgical Executive Committee member, 2015.

116 With the dominant fee-for-service payment system in BC, physicians currently benefit financially by maintaining a high volume of services billable to the provincial Medical Services Plan.

MOVE TOWARDS A TEAM-BASED MODEL OF CARE

Patients' experiences and health outcomes improve when health professionals—including nurses, physicians, physiotherapists, etc.—work together in multi-disciplinary teams using common care pathways. A common care or clinical pathway is a "structured multidisciplinary care plan which details essential steps in the care of patients with a specific clinical problem."[117] Team-based care delivered through a pathway is more timely, consistent, and appropriate—and teams also make it possible to eliminate unnecessary steps and delays, particularly when health professionals are supported to work to their full scope of practice, freeing surgeons' time to perform additional surgeries and consult with patients who have the greatest need.

In Saskatchewan, for example, there are team-based multi-disciplinary patient pathways in place for five conditions, with three more in development. In the Regina Hip and Knee Pathway Clinic, for example, it is the physiotherapist who conducts the pre-surgical assessment and calls in the orthopedic surgeon only when surgery is deemed appropriate. The Saskatchewan Ministry of Health's Ron Epp explains the benefits of these team-based, multi-disciplinary clinics:

> They are working together as a team…sharing the same chart, so everybody can see what's going on and what other people's assessments are. They are also doing warm [in-person] hand-offs with the patients, which [patients] really like. They can see that they are working as a team, [having] the patient's best interests at heart. The assessments are considerably more thorough than they ever have been before….[118]

The team-based model helps better prepare patients for surgery with a focus on maintaining their health status, which may result in reduced hospital surgery cancellations, shorter wait times, more efficient use of existing capacity and lower costs per surgical case.

In addition to conducting assessments, these multi-disciplinary teams provide education to help patients manage their condition. They learn about what surgery will and will not do and potential risks, and the team-based clinics facilitate referrals to other health services as needed. Patients may be better informed about their treatment plan and know what to expect along their journey. The team-based model also helps better prepare patients for surgery with a focus on maintaining their health status, which may result in reduced hospital surgery cancellations (patients are healthier and better prepared for surgery), shorter wait times, more efficient use of existing capacity and lower costs per surgical case. In many instances, surgery may not be appropriate for patients; the clinical pathway helps to ensure the consistency of care and reduce inappropriate surgical intervention. We turn now to provide a successful BC example of a team-based, multidisciplinary pathway clinic.

Osteoarthritis Service Integration System

Champions of health care reform in Vancouver Coastal Health Authority established the Osteoarthritis Service Integration System (OASIS) in 2006. This innovative program was created to provide a single-point of clinical contact for patients who may need orthopedic surgery. OASIS was launched as a regional VCHA program with clinics in Vancouver, the North Shore and Richmond. The program serves to reduce waits by quickly assessing patients in a team-based clinic for surgery, non-surgical alternative therapies or self-management.

OASIS was originally intended to serve as the central intake for all VCHA patients referred by GP for possible hip or knee surgery. Cindy Roberts, a former health authority administrator and one

117 Campbell et al., 1998, p. 133.

118 Interview, Ron Epp, director of strategic priorities, Saskatchewan Ministry of Health, 2015. Standardizing surgeons' surgical yield is one of the goals of this initiative, and the Saskatchewan Ministry of Health hopes to evaluate progress towards this goal when data becomes available.

Table 3: OASIS reduces demand for clinically inappropriate surgical consultations

		2012	2013	2014	2015	Total
Total number of unique clients first referred to OASIS as non-surgical (conservative)		748	1532	1651	1076	5007
% of Clients OASIS found to be	Non-surgical (conservative)	85%	89%	91%	90%	89%
% of Clients OASIS found to be	Surgical	15%	11%	9%	10%	11%
Total number of unique clients first referred to OASIS as surgical		703	1293	1290	874	4160
% of Clients OASIS found to be	Non-surgical (conservative)	48%	48%	44%	49%	47%
% of Clients OASIS found to be	Surgical	52%	52%	56%	51%	53%

Note: Year is the year of the referral date. "Referred for" was not a required field until 2012. Data in this report are up to September 30, 2015 and includes OASIS programs in Vancouver, the North Shore, and Richmond. Source: OASIS, Vancouver Coastal Health Authority.

of the OASIS founders, noted that some surgeons were opposed to the idea because they wanted to maintain their own waitlists and were concerned their income would suffer if the waitlists were managed centrally. As a consequence, some patients are referred to OASIS and others continue to be referred by the GP directly to an individual surgeon, although, over time, GPs have been increasingly referring their patients to the first available surgeon if surgery is required.[119]

OASIS has nurses, physical and occupational therapists working as a team to assess patients' appropriateness for surgery, thereby preventing non-surgical patients from filling waitlists to see a surgeon. This enables specialists to focus on those most likely to benefit from surgery. As Table 3 demonstrates, nearly half of patients (47 per cent) referred to OASIS as surgical candidates by their GP were ultimately found by OASIS to be better suited for non-surgical treatment ("conservative management"). Without OASIS, 1,955 patients between 2012 and September 2015 may have been inappropriately placed on an orthopedic surgeon's waitlist, creating longer waits for those urgently in need of surgery.

Despite being an innovative model of preventative, team-based care, the future of OASIS is uncertain. Some services have been curtailed or eliminated.

Despite being an innovative model of preventative, team-based care, the future of OASIS is uncertain. As Cindy Roberts laments, "It's hard to get something that looks the same across the region unless you run it regionally…. [But] OASIS won't be around much longer. They are already dismantling [it]. They've been doing that over the last two years." Before Roberts left OASIS, the program was planned to expand beyond hip/knee to hand, foot/ankle and shoulder osteoarthritis. However, OASIS is no longer a regional program. In order to fit within VCHA's distributed program funding model, it has been divided up across each community within VCHA, and regional coordination no longer occurs. Some services have been curtailed or eliminated.

In *Future Directions*, the Provincial Surgical Executive Committee and the Ministry of Health indicate that health authorities will develop care pathways, but it remains unclear if, and how, the Ministry of Health will coordinate this work. OASIS's team-based approach with a focus on education, prevention and non-operative care should be supported regionally and replicated provincially—and not downgraded because it does not fit within the regional funding model.

119 Interview, Cindy Roberts, former health authority administrator, 2015.

Similar to central intake and pooling, more provincial leadership is needed to take effective team-based pre-surgical innovations and expand and replicate them province-wide. This should, as with pooling, include an analysis of how and to what extent the volume incentives in the fee-for-service payment system represent a barrier to introducing a more collaborative team-based approach in pre-surgical care.[120]

REDUCE INAPPROPRIATE SURGERIES

Routine, low complexity surgical procedures often have high clinical variation, meaning that patients with similar diagnoses receive different treatments depending on when, where and by whom they are treated.

Safe, high quality surgical care means that the surgical intervention is appropriate for a patient based on available evidence and their individual health status. There is growing recognition that surgical intervention in many cases may not be appropriate for patients. These are surgeries that provide no health benefit to the patient, are risky and may result in deterioration in a patient's health status. Inappropriate surgical care may be reduced in two ways: 1) by ensuring physicians are supported to use the best available evidence in assessing whether a surgery is appropriate for their patient and, 2) by involving and fully informing patients of the potential benefits, risks and outcomes of surgery. In other words reducing inappropriate surgical intervention requires a movement towards shared decision-making between patients and health care providers, with patients actively involved in the decision to undergo surgery or pursue alternative non-operative therapies. Vancouver Coastal Health Authority's OASIS program, through a team-based clinical environment, plays an important role in helping patients determine whether surgery is appropriate based on their individual health status and preferences.

Routine, low complexity surgical procedures, such as cataract surgery, often have high clinical variation, meaning that patients with similar diagnoses receive different treatments depending on when, where and by whom they are treated, despite the clinical evidence on the optimal treatment. For example, Charles Wright's study of BC cataract surgery patients found that 26 per cent of patients reported either no change or a deterioration to their eyesight after surgery.[121] This 2002 study used patient-reported outcome measures (PROMs)—standardized and validated surveys completed independently by patients, typically before and after surgery—in order to provide a patient's perspective on their health and the appropriateness of the intervention. This evidence can then be used to identify where there are variations resulting in poor outcomes, to support clinicians to make necessary changes in their clinical practice and to inform the development of clinical practice guidelines and care pathways.

PROMs can also support greater patient involvement in shared decision-making as to the appropriateness of surgical intervention. PROMs data can, for example, be used in the development of print or electronic "decision aids" or plain-language toolkits provided to patients considering surgery. In one US study, "the introduction of decision aids was associated with 26 per cent fewer hip replacement surgeries, 38 per cent fewer knee replacements, and 12–21 per cent lower costs over six months."[122] That is to say, patients who were provided with a decision aid were less likely to choose surgery than those who were not. This underscores the important role decision aids play in shared decision-making where patients have evidence in front of them and can make a fully informed choice about whether surgery is best for them considering their health status and lifestyle preferences.

120 The current and dominant physician compensation system—self-employed physicians working as fee-for-service contractors—has physicians financially benefitting from the volume of services they bill the BC Medical Services Plan.

121 Wright et al., 2002.

122 Arterburn et al., 2012, p. 2094.

For the public system, addressing surgical appropriateness, through the use of PROMs, decision aids and shared decision-making, may reduce overall demand for inappropriate surgery and costs to the public system. While there is increasing interest in collecting patient-reported outcomes, they have not been implemented widely in Canada. Saskatchewan piloted the collection of PROMs for several care pathways, including hip/knee replacement, prostate care, pelvic floor care and lower-leg ischemia.[123] The province has also recently developed an appropriateness of care framework, which will guide the Saskatchewan Ministry of Health as it engages clinical areas to develop and implement initiatives to improve care appropriateness. However, finding a sustainable PROMs data collection and reporting mechanism remains one of the challenges the Saskatchewan Ministry of Health has yet to tackle. Internationally, PROMs are collected for joint replacement procedures in the UK, Sweden, the Netherlands and New Zealand. The UK has been collecting PROMs for hip/knee replacement surgeries, hernia repairs and varicose vein surgeries since 2009.[124]

In BC, initial PROMs were collected with the intention of evaluating the effectiveness of the OASIS program at reducing unnecessary surgical interventions and improving patients' health outcomes. However, this has not occurred since OASIS is no longer a regional health authority program with regional coordination.[125] Nevertheless, while PROMs are not collected and used in any standardized manner across the province, there are a number of research and practice improvement projects currently underway and significant interest at the health authority level. For example, Dr. Stirling Bryan, director of the Vancouver Coastal Health Research Institute's Centre for Clinical Epidemiology & Evaluation, is engaged in a region-wide quality improvement project that builds on Charles Wright's research on appropriateness of cataract surgeries. Bryan's improvement work is supported by the health authority's ophthalmology lead, Dr. David Maberley, and the practising cataract surgeons who are participating in the initiative. Using a PROM tool selected by the surgeons, they are planning, over the next 18 months, to survey a sample of patients cared for by all surgeons practising as part of the ophthalmology group in Vancouver Coastal Health. To date they have a 70 per cent return rate for the post-surgery follow-up survey. The goal is to use PROMs data to identify variations among surgeons in practice styles and outcomes. Based on these findings, the health authority will then work with individual surgeons to support practice changes aimed at improving both outcomes.[126] These data will also help to better understand the link between PROMs data and appropriateness.

The BC Ministry of Health needs to provide more leadership in developing a strategy to address appropriateness in surgical care province-wide.

This is an important and promising initiative, but again it is driven and supported by local and regional champions and is not yet part of a coordinated provincial plan for system-wide quality improvement. The BC Ministry of Health needs to provide more leadership in developing a strategy to address appropriateness in surgical care province-wide.

MODERNIZE INFORMATION SYSTEMS

Modernized and integrated information systems are required to develop robust, data-driven waitlist management strategies and quality improvement initiatives. The Scottish government's information strategy has been key to reducing wait times. NHS Scotland has invested in information systems that accurately measure and report on the whole patient journey, including wait

123 Canadian Institute for Health Information, 2015.

124 Ibid.

125 Interview, Cindy Roberts, former health authority administrator, 2015.

126 Interview, Dr. Stirling Bryan, director of the Vancouver Coastal Health Research Institute's Centre for Clinical Epidemiology & Evaluation, 2016.

times for accessing diagnostic tests and non-surgical care. NHS Scotland's Information Services Division reports on a wide range of performance and quality indicators, producing some of the best health systems information in the world.

In the Scottish experience, improving information collection and reporting has driven quality improvement and wait time reductions. As NHS Scotland's Jim Crombie notes,

> Data is imperative. There needs to be a robustness to data, both in terms of characterizing demand, understanding what the referrals into the service are looking like, and… performance challenges…. There must be one source of reporting…and that central report needs to be the basis of decision-making.[127]

Data can be used to engage clinicians and help them understand the role they play in system improvements. Crombie says, "As difficult as some of those conversations can be, sustainable change is only delivered by doing that."

BC's health information systems and IT infrastructure should be greatly enhanced in order to report on the whole patient journey, with a provincial plan to prioritize these efforts.

One information technology and information management innovation of particular note is NHS Scotland's Picture Archiving and Communications System (PACS). It has played a significant role in reducing waits. An MRI obtained at an outpatient clinic in the public system can be centrally uploaded and electronically examined anywhere in the country. "We were able to use that to establish outpatient clinics and then have specialists reporting through a smaller number of specialist centres," explains Crombie. "That increased our productivity and reporting. It helped us reduce our wait time for diagnostic imaging. About 10 years ago, we probably had a 24-month wait for an MRI."[128] Now in Scotland, 90 per cent of patients receive diagnostic tests in under six weeks.[129] As the Scotland example illustrates, there are good models of delivering centralized diagnostic imaging in the public system using special outpatient clinics equipped to archive images into a central system, enhancing accessibility and efficiency across the health care system.

Currently in BC, the Surgical Patient Registry remains the most significant information management innovation associated with surgical care. While it reports the wait from surgery booking (following surgical consultation) to completion (Wait 2), it does not include other significant waits of the patient journey (see Table 1), including waits from GP referral to the consultation with a specialist (Wait 1), for diagnostic testing (Wait 3), from surgery completion to recovery (Wait 4) or to access community care and home supports. The Surgical Patient Registry is a good start, but it needs improvement. The Wait Time Alliance's grade for BC's Surgical Patient Registry slipped from "A" to "B" between 2014 and 2015, noting the need to track data on radiation therapy, diagnostic imaging and other non-surgical procedures.[130]

BC's health information systems and IT infrastructure should be greatly enhanced in order to report on the whole patient journey, with a provincial plan to prioritize these efforts. Wait time reporting should also extend to non-surgical areas, including time to access home supports and community care, necessary to reduce hospital bed shortages. At the time of writing, the Provincial Surgical Executive Committee and Ministry of Health are moving forward with an electronic booking solution, which will link surgeons' offices with the hospital operating room booking system. The intent of this initiative, to our understanding, is to gradually expand this from reporting Wait 2 (surgical consult to surgery completed) to include Wait 1 (GP referral to surgical consult) of the patient journey as well. This is a promising development, which should provide accurate

127 Interview, Jim Crombie, chief officer, Acute Hospital Services, Lothian Health Board, NHS Scotland, 2015.
128 Interview, Jim Crombie, chief officer, Acute Hospital Services, Lothian Health Board, NHS Scotland, 2015.
129 Information Services Division, 2015b.
130 Wait Time Alliance, 2015, p. 6.

information on wait times for surgical consultations (Wait 1) and completed surgical procedures (Wait 2) by community.

While it appears the BC government is focused on better information management to report Wait 1 (GP referral to surgical consultation) and Wait 2 (surgery booking to completion of surgery), this remains a partial solution. In order to reduce wait times in the long term, the provincial government, like Scotland, needs an integrated information management system to accurately track waits across the whole health care system. To be effective, this should include non-surgical areas, such as waits to see a GP, receive diagnostic testing (Wait 3) and gain access to community care and home supports. A fully integrated information management system is necessary to understanding what parts of the system are contributing to long waits and how those bottlenecks can be addressed.

IMPROVE ACCESS TO COMMUNITY CARE AND HOME SUPPORT

Increasing access to affordable and appropriate community-based resources for seniors will go a long way in addressing hospital bed shortages.

Better access to affordable, high quality home and community-based care, especially for seniors, will reduce hospital bed shortages, cancellations of elective surgeries and, ultimately, surgical wait times for all patients. Home and community-based services include residential care (also called long-term care), home support (e.g., help with housekeeping, bathing, cooking, and taking medications), home nursing, and hospice or end-of-life care. The majority of patients occupying hospital inpatient beds because they cannot be discharged, due to the lack of community-based alternatives, are seniors and are referred to as alternate level of care (ALC) patients.[131] As our population ages, more seniors will require affordable, high quality community resources—residential and palliative care and home health services.[132] A 2012 Canadian Institute for Health Information report suggests that persons with complex needs, who lack personal supports and those with symptoms of dementia, including behaviour challenges, are more likely than others to be in acute care prior to admission to residential care.[133] Increasing access to affordable and appropriate community-based resources for this population will go a long way in addressing hospital bed shortages. The CCPA's 2012 report *Caring for BC's Aging Population* extensively analyzes these challenges and offers policy solutions.[134]

More recently, the Wait Time Alliance strongly reaffirmed its position that "the ALC issue represents the single biggest challenge to improving wait times across the health care system."[135] The organization emphasizes the urgency of improving access to seniors' care in order to reduce the high rates of ALC patients. Doing so requires both home support services and investments in appropriate, affordable and high quality residential care. "If we can improve how we care for our seniors," the Wait Time Alliance states, "we will go a long way toward creating a high-performing health care system, thereby benefiting all patients."[136] The College of Physicians and Surgeons of BC, too, recognizes that wait time challenges do not stem primarily from the lack of public sector operating room capacity but that "the fundamental problem is bed access."[137]

131 In Canada, the median age of ALC patients is 80 years old. Canadian Institute for Health Information, 2009, p. 6.
132 Home health services include home nursing, rehabilitation services and home support.
133 Canadian Institute for Health Information, 2012.
134 Cohen, 2012.
135 Wait Time Alliance, 2015, p. 2.
136 Ibid., p. 7.
137 Interview, College of Physicians and Surgeons of BC, 2015.

In Scotland, ensuring access to appropriate community-based care has been key to reducing waits, which "[prevents] patients [from being] in hospital longer than they need to be…[and] [ensures] you don't admit patients that don't need to be admitted."[138]

Currently in BC, too many ALC patients continue to occupy hospital beds because of inadequate community resources. A 2011 study from the Canadian Health Services Research Foundation found that one-half of ALC patients in BC were awaiting placement in residential care and others were waiting for home care, assisted living or rehabilitation services.[139] In 2014/15, 13 per cent of total hospital inpatient days were classified as ALC days, with 18 per cent of total inpatient days for those 65 and older classified as ALC days.[140] The high level of ALC hospital inpatient days puts an unnecessary strain on hospital beds that could otherwise be occupied by patients recovering from elective surgery.

In June 2015, the BC Ministry of Health launched a very comprehensive and promising provincially led initiative to provide more integrated team-based care and support to seniors with moderate to significant health challenges living in their own homes. The goal of this initiative is to reduce the flow of this patient population into emergency services and inpatient hospital beds.[141] As noted above, however, half of the patients in BC in ALC beds are waiting for placement in residential care and others require assisted living and rehabilitation services. And yet, the possibility of investing in public infrastructure is not on the table. The *Future Directions* policy paper assumes that there will be "extremely limited future capital investments."[142] This makes no sense given the assessment from the Wait Time Alliance and BC's College of Physicians and Surgeons that bed access is the single biggest barrier to reducing wait times. But it does explain why the idea of three-day inpatient stays in private, for-profit facilities has some appeal.

Our recommendation, on the other hand, is very clear: more investment in public infrastructure should be on the table, and the decision about what kind of facility services are required should be based, at least in part, on an analysis of the care needs of those who are most likely to occupy ALC beds, and even medical beds, in BC's hospitals.

138 Interview, Mike Lyon, senior adviser, Health Delivery Directorate, Scottish Government, 2015.

139 Sutherland and Crump, 2011, p. 25.

140 BC HealthIdeas, accessed December 18, 2015, at: http://public.healthideas.gov.bc.ca/portal/page/portal/HealthIdeas.

141 Ministry of Health, 2015.

142 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 8.

Recommendations for successful public sector innovation in BC

THE *FUTURE DIRECTIONS* REPORT ACKNOWLEDGES the "excessive use of pilots" in Canada and the fact that although many of them "have shown promising results" they "have not been formally evaluated or had their funding built into the routine annual multi-year funding stream."[143] This issue is not adequately addressed or resolved in the *Future Directions* report, as shown by the lack of attention given to challenges faced by both the Richmond Hip and Knee Reconstruction Project and OASIS. And while the lack of a transparent process—for how the report's recommendations will be implemented by the Provincial Surgical Executive Committee—puts us at considerable disadvantage, the evidence from Scotland, Saskatchewan's initiatives to increase capacity and efficiencies in the public system and BC's successful local and regional pilot initiatives point us in a clear direction.

The evidence from Scotland, Saskatchewan's initiatives to increase capacity and efficiencies in the public system and BC's successful local and regional pilot initiatives point us in a clear direction.

For public sector initiatives to successfully reduce wait times and improve the quality and efficiency of surgical care, there must be leadership and commitment to:

1. **Establish an ongoing and provincially coordinated process for making the needed changes in publicly delivered surgical services**

   Scotland has been working in a consistent direction for 20 years providing national leadership to regional authorities to support front-line providers making on-the-ground changes to improve the efficiency and quality of publicly delivered surgical services. For four years in Saskatchewan, from 2010 to 2014, reducing wait times was a priority initiative for the Ministry of Health. A wide range of stakeholders were consulted and Ministry of Health staff were tasked with taking leadership roles on a broad range of system improvement strategies (e.g., pooled referrals, team-based care, operating room efficiencies, etc.) and expected to support local practitioners to change their practice environment. Now that the strategy is no longer a provincial priority, there has already been an increase in wait times and greater reliance on private sector delivery.[144]

143 Ibid., p. 39.
144 Martin, 2014; McKinnon, 2015; Modjeski, 2016.

In BC, while local innovators have been working to improve the efficiency and effectiveness of their services for more than 10 years, the Ministry of Health has, until very recently, been focused almost exclusively on providing additional funding and introducing financial incentives to increase the volume of surgeries performed over the short term. The *Future Directions* report acknowledges that these short-term infusions of money will not reduce wait times over the longer term.[145] We also know that very successful local and regional innovations, like OASIS and Richmond Hip and Knee, can be undermined if they lose their champions on the senior executive team and/or do not fit into the standard way services are currently organized.

Very successful local and regional innovations can be undermined if they lose their champions on the senior executive team and/or do not fit into the standard way services are currently organized.

The *Future Directions* report represents the first attempt by the Ministry of Health to develop a comprehensive planning document for reducing wait times. It recommends the province take the lead in developing up-to-date information and prioritization codes to improve waitlist management, creating province-wide and publicly accessible performance measures and amending provincial legislation to allow for up to three-day overnight stays in private facilities. But what is not mentioned as a provincial priority is even more important: that is, a provincial role in leading the system level transformations related to pooled referrals, team-based care, operating room efficiencies and strategies to reduce inappropriate surgeries. These areas of innovation have proven highly effective in other jurisdictions at reducing wait times in the public system over the longer term. It is in these areas that we need to see significantly more commitment from the provincial government if we are to be successful in creating an ongoing and fully integrated provincial strategy for reducing wait times in the public system.

2. Create improvement teams provincially to work with local providers to spread system-wide best practices

In Scotland, the national government has "improvement teams" that support the regional authorities to work with groups of surgeons, other practitioners and system managers so they can introduce changes in practice related to central intake and pooled referrals, evidence-based clinical care pathways for improving quality and appropriateness, operating room efficiency, teamwork, etc. These improvement teams play a critical role in spreading and entrenching effective local innovations (i.e., best practices) system-wide.

In Saskatchewan, Ministry of Health staff, working in similar areas, also developed provincial-level best practice strategies, although somewhat less hands-on because physicians and surgeons, unlike in Scotland, are independent fee-for-service contractors and not direct employees of the regional health authorities. In addition, since wait times are no longer the primary priority in Saskatchewan, some of these initiatives no longer have Ministry staff available to provide provincial coordination, support, and leadership.

The *Future Directions* report acknowledges the need for an "effective and adequately resourced change management process that engages stakeholders and works with existing organizations and professional cultures."[146] And yet, capacity at the BC provincial level to lead an effective change management process is very limited. The Ministry of Health has a very small secretariat working full-time on their wait time reduction strategy, and all of the members of the Provincial Surgical Executive Committee, the committee responsible for developing the policy framework, work in other full-time positions as surgeons and/or health authority administrators. And as far as we can discern, no one

145 Ministry of Health and the Provincial Surgical Executive Committee, 2015, p. 38.
146 Ibid., p. 4.

is working at the provincial level on the key improvement strategies needed to achieve system-wide transformation, such as pooled referrals and team-based care.

There are, however, important provincial precedents in BC that are ongoing and have been quite effective at spreading evidence-based improvement strategies. We provide two examples. The first is the Practice Support Program, a joint initiative of the Ministry of Health and Doctors of BC, which provides assistance to family physicians across the province interested in changing how they practise family medicine to better support their patients with chronic health challenges. The Practice Support Program includes on-line learning modules, small group learning sessions, coaching and peer support and has provided on-going support to family physicians for more than 10 years.[147] The second is the National Surgical Quality Improvement Program that was initially developed by the American College of Surgeons as a strategy for reducing surgical infection and complication rates and improving both the quality and cost-effectiveness of surgical care.[148] It was introduced in BC as a provincial initiative and has expanded from two hospitals in 2006 to 25 in 2014.[149] These examples point to what can be achieved when the province takes leadership in developing improvement initiatives. In terms of the key strategies needed to significantly reduce wait times over the long term, much can be learned from the Scottish government's use of improvement teams.

3. Fully commit to enhancing the public services needed to reduce surgical wait times

The policy prescriptions in the *Future Directions* report are constrained by the province's refusal to consider public infrastructure investments.

In addition to taking provincial leadership to improve surgery processes, teamwork, central intake and pooling, the BC government needs to seriously consider investing in the infrastructure needed to take the pressure off of overcrowded hospitals. The policy prescriptions in the *Future Directions* report are constrained by the province's refusal to consider public infrastructure investments and insisting that future capital investments are extremely limited. The solution to hospital overcrowding does not necessarily mean building more hospital beds, but it does mean more community beds are required to support frail seniors and others who are currently occupying hospital beds because community alternatives are not available. Denying the reality that investments in public infrastructure are urgently required means that the province with be increasingly reliant on buying capacity from private for-profit clinics, hospitals and residential care facilities—a policy direction bound to create more problems than it solves.

Scotland is fully committed to developing public sector wait time solutions, and it has done it without entrenching its reliance on the private for-profit sector. One of the key advantages Scotland has over BC and Saskatchewan is that its physicians and surgeons work directly for the regional health authorities and not as independent fee-for-service contractors. As we document in this report, alternatives to the fee-for-service compensation model would remove one of the most significant barriers to effectively transferring responsibility for waitlist management from the individual surgeon to the health system.

In other words, effectively addressing the challenges of long waits for health care services requires moving in the direction of greater public delivery and innovation, and not going down the road that will increase BC's reliance on private sector surgical delivery over the long term.

147 General Practice Services Committee, 2015.
148 American College of Surgeons, 2016.
149 Surgical Quality Action Network, 2014.

Conclusion

The report's recommendations are more focused on expanding and entrenching the role of the private for-profit sector, than on the provincial leadership needed to scale-up local and regional innovations that have proven effective.

WE ARE AT AN IMPORTANT CROSSROADS in the future of surgical care in BC. The BC government's 2015 report, *Future Directions for Surgical Services in BC*, recognizes the need for more provincial leadership to improve the public system and reduce waits, and yet the same document proposes a significant expansion of private, for-profit delivery of surgical services.

The problem with going in these two directions at once is that it undermines the urgency of public sector innovation and takes us farther down the road of health care privatization. This is exemplified by the fact that the report's recommendations are more focused on expanding and entrenching the role of the private for-profit sector, than on the provincial leadership needed to scale-up local and regional innovations that have proven effective at improving the quality, efficiency and timeliness of publicly delivered surgical services.

It is well understood that once the private sector has a guaranteed public revenue stream, they will expend significant resources in lobbying and media strategies to ensure that their sector continues to grow and expand.[150] In BC we have witnessed the very public role that Brian Day played in successfully lobbying the provincial government to experiment with activity-based funding, a strategy that proved unsuccessful at reducing wait times. Entrenching private delivery in the health care system, through the proposed three-day stays in private facilities and the contracting-out already under way in the Vancouver Island Health Authority, will give the for-profit surgical sector a much greater foothold in BC.

The better way forward is for the BC government to fully commit to developing, coordinating and sustaining public sector wait-time solutions. As the experience in Scotland so clearly demonstrates, there is no need to entrench private-sector surgical delivery if there is a consistent focus and commitment to better utilize the existing capacity in the public system by improving the quality and efficiency of surgical services and increasing access to community care. By choosing to become a leader in public sector innovation, BC's public health care system can be transformed into the integrated, patient-centred, and high-performing system that we know is possible.

150 See Jansen, 2009, p. 59.

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Appendix A: Methods and Interviewees

THIS RESEARCH REPORT DRAWS ON 18 key informant interviews, media accounts and an extensive review of the peer-reviewed and policy literatures. Semi-structured interviews were conducted in fall 2015 and early 2016. Interviews were typically one to two hours in length, and in numerous cases the authors conducted follow-up interviews or engaged in email correspondence with the interviewees to seek clarification. In cases where interviewees consented to audio recording, interviews were transcribed.

INTERVIEWEES

Dr. Stirling Bryan, director, Vancouver Coastal Health Research Institute's Centre for Clinical Epidemiology & Evaluation; professor, School of Population and Public Health, University of British Columbia

Terry Blackmore, director, Quality and Continuous Improvement, Saskatchewan Ministry of Health

Mark Chase, executive director, Decision Support, Vancouver Coastal Health Authority

Richard Copland, head of Access, Workforce, and Performance Directorate, Scottish Government

Jim Crombie, chief officer, Acute Hospital Services, NHS Lothian Board (Scotland)

Ron Epp, director, Strategic Priorities, Saskatchewan Ministry of Health

Dr. Pierre Faber, ophthalmologist, Head of Ophthalmology, Providence Health Care

Debra Gudmundson, D. Gudmundson Healthcare Consulting; former health administrator, Saskatoon Health Region

Dr. Ken Hughes, orthopedic surgeon and Provincial Surgical Executive Committee member

Jennifer Keefe, health administrator, Vancouver Coastal Health Authority

Mike Lyon, senior advisor, Healthcare Access and Sustainability, Scottish Government

Crystal McKaig, project manager, Hospitals and Specialized Services, Saskatchewan Ministry of Health

Cindy Roberts, former health administrator, Vancouver Coastal Health Authority

Cori Ross, health administrator, Vancouver Coastal Health Authority

Dr. Jason Sutherland, faculty, UBC Centre for Health Services and Policy Research; associate professor, UBC School of Population and Public Health

Dr. Kishore Visvanathan, urologist; currently leading the quality improvement initiative at Saskatoon Urology Associates

Two representatives from the College of Physicians and Surgeons of BC

Appendix B: Provincial Surgical Executive Committee Members

PROVIDED VIA EMAIL BY THE BC MINISTRY OF HEALTH, January 28, 2016. (The names of the two patient representatives on the committee were not released.)

Marilyn Copes (Co-Chair)

Dr. Andy Hamilton (Co-Chair)

Dr. David Albiani

Dr. Peter Blair

Dr. Sukh Brar

Dr. Sam Bugis

Collette Christney

Dr. Ian Courtice

Alison Dormuth

Shelley Hatcher

Cormac Hikisch

Dr. Ken Hughes

Janine Johns

Cindy Laukkanen

Barb Lawrie

Shari McKeown

Dr. Trina Montemurro

Dr. Roanne Preston

Pam Ramsay

Dr. Gary Redekop

Susan Scrivens

Dr. Erik Skarsgard

Dr. Mike Stanger

Dr. Chris Taylor

Dr. Paul Whelan

Maggie Zhang

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