

10 Years On Revisiting the Saskatchewan Surgical Initiative

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Contents

Executive Summary / i

Introduction / 1

Saskatchewan Surgical Initiative—Background and Description / 2

The Saskatchewan Surgical Initiative and Patients Waiting for Surgery / 8

Assessing the Wait-Time Data / 14

Discussion and Concluding Comments / 20

References / 23

About the Authors / 28

Acknowledgments / 29

Publishing Information / 30

About the Fraser Institute / 31

Editorial Advisory Board / 32

Executive Summary

- ◆ Private delivery of surgical procedures is a common feature of most high-performing universal health-care systems. However, the practice is highly controversial in Canada.
- ◆ The Saskatchewan Surgical Initiative (SSI), which was in place from March 2010 to March 2014, offers an informative case study of how publicly funded care provided by private clinics can contribute to more timely delivery of specific health-care services.
- ◆ While the Saskatchewan Surgical Initiative was in place, Saskatchewan went from having one of the longest wait times in Canada for clinical procedures to being one of the best performers. Furthermore, contrary to criticisms of the SSI, universal access to health care in the province was not compromised by outsourcing medical procedures to privately owned for-profit clinics.
- ◆ Outsourcing to private clinics was constrained by a range of requirements and regulations intended to protect patient access to publicly provided care and to control costs.
- ◆ Over the period from March 2010 to March 2014, there was up to a 75% reduction in the number of patients waiting more than three months for surgery. While some reduction in wait times took place prior to the introduction of the Saskatchewan Surgical Initiative, there was a substantial acceleration in the rate of decline in the number of patients waiting more than three or six months between the time an operating room was booked and the time of treatment. Wait times then increased substantially after the SSI ended.
- ◆ A review of the SSI clearly demonstrates that, even in a limited and restricted setting, private for-profit clinics can have a positive and significant impact on the patient experience and can serve as a vital partner in wait-time reduction strategies. Moreover, the contribution to improved patient access would likely have been even greater were it not for direct and indirect regulatory restrictions on the volume of services supplied by private, for-profit clinics.

Introduction

Private delivery of universally accessible surgical care is a common feature of many high-performing universal health-care systems around the world (Barua and Esmail, 2015). Private surgical clinics have also contributed to successful programs to reduce wait times in universal-access health-care systems.¹ In Canada, however, governments contracting with private providers of surgical care is often controversial, with opponents frequently raising concerns about whether the practice would undermine the existing government-run universal system. But, as provinces struggle to tackle persistent surgical backlogs that were growing to record levels long before the COVID-19 pandemic and that continue to reach new highs year after year despite continued increases in government health-care expenditures, it is useful to once more examine the benefits of using private clinics within Canada’s universal health-care framework.

Canadians seem eager for a political debate on this issue. A recent survey reported that 78% of Canadians support allowing more surgeries and tests to be performed in private clinics, although 40% only support this policy to clear the post-pandemic surgical backlog (Angus Reid, 2023).

One relatively recent example of how publicly funded care provided in private clinics can contribute to more timely delivery of universally accessible health-care is provided by Saskatchewan, where third-party, for-profit private clinics played a key role in delivering publicly funded care during the Saskatchewan Surgical Initiative (SSI) between March 2010 and March 2014. This governmental initiative contributed to substantially reduced wait times for patients, helping move the province from one of the worst performers in Canada to one of the provinces with the shortest waits for medically necessary care. And, contrary to criticisms of the SSI, private participation in the delivery of services did not compromise universal access to health care in the province.

This study describes and assesses the Saskatchewan Surgical Initiative, including its key features and its effect on surgical wait times.² It begins with an outline of the main features of the SSI and a brief discussion of its early history and then examines changes in wait times before, during, and after the end of the SSI.

1 Moir and Barua (2024), for example, provide a detailed explanation of how such contracting works within Australia’s universal health-care framework. For examples of programs to reduce wait times, see Hurst and Siciliani, 2005; Borowitz and Moran, 2013.

2 This study draws on McKinnon, 2016 for background and details of the Saskatchewan Surgical Initiative.

Saskatchewan Surgical Initiative— Background and Description

In 1993, when the Fraser Institute published the first national measurement of wait times for medically necessary care in Canada, Saskatchewan reported a median wait of 9.8 weeks between referral by a general practitioner and treatment. This was the third shortest wait in the country: only Quebec and Ontario reported shorter wait times. However, by 1997, wait times in Saskatchewan were the longest in Canada, with patients waiting almost twice as long (17.1 weeks) for medically necessary care as they did in 1993.³

Reflecting growing public concern about the delays patients were facing in receiving health care across Canada, Saskatchewan both participated in and launched various initiatives between the late 1990s and mid-2000s to reduce wait times. The various approaches included participating in the Western Canada Waiting List Project (WCWL), which focused on developing standardized patient prioritization tools to improve the management of waiting lists; increasing health-care funding with the stated goal of improving access; agreeing to benchmark maximum wait times for select health services as part of a multi-year funding agreement with the federal government; and implementing a province-wide surgical registry to track and report wait times.⁴ Despite the various provincial, multi-provincial, and provincial-federal initiatives pursued over this period, Saskatchewan continued to report the longest wait times in Canada almost every year between 1997 and 2008.⁵

Continued public concern about wait times for health care, confirmed in a 2008 report commissioned by the Government of Saskatchewan, led to work on a program focused on the coordination and delivery of surgical services in Saskatchewan (*Second Street*, 2022). The Saskatchewan Surgical Initiative (SSI) was launched in 2010 with the goal of shortening surgical wait times and improving the experience of patients in Saskatchewan. The four-year program that included a number of actions aimed at reducing wait times in the province seemed bold and ambitious from a Canadian perspective, although it was arguably a relatively modest reform compared to international practice.

3 By comparison, the national average wait times were 9.3 weeks in 1993 and 11.9 weeks in 1997 (Moir and Barua, 2022).

4 See Postl, 2006, Hadoorn, 2000, and Priest, Rachlis, and Cohen, 2007 for a discussion of the main initiatives.

5 In 2006, that distinction went to New Brunswick, with Saskatchewan reporting the second-longest wait amongst provinces (Esmail, 2006).

Features of the Saskatchewan Surgical Initiative

One of the stated goals of the SSI from the outset was that no patient would wait longer than three months for surgery by the anticipated end of the program in 2014, and that shorter wait times should be realized in the future. At launch, the province faced a surgical backlog of more than 27,500 patients: over 15,000 had waited more than three months and approximately 10,000 had waited over 6 months for surgery (Duncan, 2014). MacKinnon (2016) describes seven key features of the SSI:

1. a *Patient First* philosophy;
2. specific wait-time targets and guarantees;⁶
3. centralized pooling of surgical referrals and standards for prioritization;
4. increased capacity via private clinics;
5. collaborative decision making and improved integration and coordination of the provincial system;
6. accountability and performance reporting;
7. clear and frequent communication.

In addition, the province announced its intention to free up acute-care beds by transitioning patients to long-term care more efficiently, maximizing operating room time by expanding its Surgical Information System, and eliminating inefficiencies in hospitals (Government of Saskatchewan, 2010). Central to the SSI was a view that eliminating bottlenecks throughout the system, from physician practices and referral pathways to hospital operating rooms and patient recovery, would allow the province to meaningfully improve wait times for patients.

There were two features of the SSI that represented a clear departure from previous provincial attempts to reduce wait times:

1. the proposal to contract publicly funded care to “third parties” (including private, for-profit clinics) in order to expand the province’s surgical capacity; and
2. the decision to create a province-wide centralized registry that would allow patient referrals to be pooled using standardized prioritization tools.

6 It should be noted that, on their own, wait-time guarantees have been largely unsuccessful in reducing wait times unless paired with sanctions or when they incorporate or mimic market-type incentives (Esmail, 2013). However, they arguably strengthened government’s accountability for achieving the goals of the SSI.

Contracting private clinics

The first feature is arguably the more substantive and controversial of the two and continues to be a hotly debated issue in several provinces today. The introduction of private contracting under the SSI was certainly the source of much debate in Saskatchewan at the time, with opponents to reform suggesting the policy would damage the province's health-care system in ways that would lead to longer wait times and higher costs than would be the case with purely public provision of services.⁷ Interestingly, public opposition to private contracting arguably faded towards the end of the SSI project following reductions in wait times and consistently high patient-satisfaction ratings (MacKinnon, 2016).

The provincial government was cautious in its approach to introducing private contracting for surgical services, publicly setting out several key principles for the contracting process:

1. third-party delivery must support a patient-first approach to health care through improving access, quality, and choice for patients and their families;
2. third-party delivery must fully comply with the principles and guidelines of the Canada Health Act, and all relevant provincial legislation and regulations;
3. third-party delivery must be fully integrated within the publicly funded, publicly administered health system;
4. third-party delivery must meet all necessary health-system safety and quality standards;
5. third-party delivery must be implemented through an open, consistent, equitable, and fully transparent selection process;
6. third-party delivery must be financially responsible, and the cost of the services must be equal to, or less than, what is offered by the publicly delivered health system.

(MacKinnon, 2016: 27)

The first principle outlined for private contracting is very much a restatement of the central goals for the SSI. The second and third principles may have been a response to opponents of reform, who had suggested private contracting was contrary to the Canada Health Act (CHA) (MacKinnon, 2016). They are also an important position for any reforming province to state as a pre-emptive response to federal disagreement with the reforms, recognizing that federal

7 Opponents of health-care reform in Saskatchewan included those who typically oppose private contracting for delivery of health care in Canada: for example, health-care unions, the local Saskatchewan Health Coalition, and the Canadian Doctors for Medicare.

acceptance of the reforms is necessary to ensure continued access to federal cash transfers. Federal cash transfers are governed by the terms and conditions of the CHA, and violations of the CHA can result in either partial or total withdrawal of cash transfers to a province. While the CHA does not explicitly disallow private, for-profit provision of surgical and hospital services, the federal government may interpret the initiative as violating the CHA through its own interpretation of the undefined term “reasonable access”. While this action by the federal government might seem unlikely, it has in the past (in 1995 and 1996) expressed concerns about private clinics and suggested that regulations might be required to ensure reasonable access for Canadians (Esmail and Barua, 2018).⁸

The fourth principle appears at first glance to be a response to possible public concerns about the quality of care provided outside hospital settings by new providers, but it also acknowledges the need for clear legislation and regulations within which clinics could operate and contracts could be established. In Saskatchewan, the Health Facilities Licensing Act (HFLA) of 1996 provided a legal framework for the creation and operation of private clinics. The HFLA made explicitly clear that facilities could be privately owned, but it was silent on the profit status of those facilities and created enough “barriers to virtually insure that no such facilities could effectively operate” (McIntosh and Duci, 2009: 47). The barriers included a requirement that private facilities must be either fully publicly funded or fully privately funded with charges not exceeding the public fee schedule used to reimburse physicians and other providers, and that facilities could not charge extra fees for services deemed superior to those offered in the public system (McIntosh and Duci, 2009; Allin *et al.*, 2020).⁹ The licensure process also required accreditation from the College of Physicians and Surgeons of Saskatchewan to the same standard as those required of public hospitals, and a determination by the Regional Health Authority that there was sufficient need for a facility. Once these conditions were met, the Minister still reserved the authority to refuse the license application or to impose terms and conditions the minister considered appropriate.

Perhaps as a result of these barriers, as Allin and colleagues (2020) note, there was no significant private-sector activity for medically necessary services in Saskatchewan until the SSI established contracts with third-party clinics. This makes the SSI’s use of clinics markedly different from successful approaches employed in nations like Spain, Portugal, and the United Kingdom where already-active private clinics focused on serving private-sector patients were brought into the universal scheme to increase the availability of services and help reduce delays (Esmail,

8 For more on the Canada Health Act and how it is a barrier to health-policy reform in Canada’s provinces, see Esmail and Barua, 2018.

9 Dual practice for physicians (that is, working in both publicly funded and privately paid sectors) is also disallowed in Saskatchewan.

2013). By contrast, Saskatchewan’s approach limited the supply of clinical services provided outside the publicly funded sphere by restricting the ability of private health-care providers to use otherwise idle time not purchased by the government to provide additional services to patients paying privately. This restriction may have placated opponents of health-care reform and the federal government to some extent, but it might also have limited the extent to which the SSI reduced patient wait times.

The fifth principle, namely an open and transparent process, was employed by the SSI to directly address some of the arguments made by opponents of private contracting. For example, the request that proposal criteria be made public included the requirement that surgical clinics be evaluated on their credentials and experience, their implementation schedules, and their pricing. The contracts with private clinics specified the number of procedures to be performed over a specified period, with pre-identified costs and with regional health authorities determining which patients would go to the private surgical clinics.¹⁰ The clinics were also required to provide human resources plans to ensure there was no reason for concern that health professionals were being attracted away from public facilities.

The requirement that private clinics deliver procedures at a cost that was the same as, or lower than, that charged by their public counterparts turned out to be a significant challenge, because prices in the public system could not be readily and accurately identified. An approach for determining the costs of procedures in public hospitals was developed based on “procedural activity-based costing” that already had a track record in Ontario and Alberta. The costing framework was released a few months after the SSI was launched in 2010.

Contracts in the first year were awarded to Omni Surgery Centre and Saskatoon Surgi-Centre to perform publicly funded arthroscopic shoulder and knee procedures (*Guelph Mercury*, 2010). However, the number of surgeries contracted in each of these facilities was fairly limited; each centre performed just over 300 surgeries in the fiscal year 2010, with another 800 delivered by each in fiscal year 2011.¹¹ The provincial government deemed that progress on reducing the

10 Having the regions select patients for treatment in private clinics may have been in response to concerns raised by opponents about private clinics “cherry picking” easier cases and leaving public hospitals with a more medically complex patient load (MacKinnon, 2016). Avoiding that outcome may not have been an optimal policy decision, however, since having acute-care hospitals (public or private) focus on more medically difficult cases while leaving medically easier cases to specialty clinics may produce better outcomes compared to having all patients (no matter their level of medical complexity) treated in full-service facilities (Ruseski, 2009). Competition between clinics and hospitals for patients can also be beneficial. A central challenge for governments is to ensure that the care provided to more complex patients is remunerated appropriately, so that full-service hospitals do not need to rely on financial cross-subsidization from care provided to less complex patients, and that remuneration for less complex patients appropriately reflects the lower cost of caring for them (particularly in specialized clinics focused on routinized, less risky procedures with commensurately lower capital costs).

11 Personal correspondence, Government of Saskatchewan (August 29, 2023).

number of patients who had been waiting an exceptionally long time within the first year was unsatisfactory, so “[i]t was decided that in addition to ramping up surgical capacity in publicly operated facilities, an expansion of publicly funded third-party delivery of selected surgical and diagnostic services should also be added to the Saskatchewan Surgical Initiative to further reduce wait times” (Second Street, 2022). Multi-year contracts were subsequently awarded to Surgical Centers Inc. in both Regina and Saskatoon (under the name Prairieview Surgical Center), each location opening private facilities in 2012 (French, 2012; Duncan, 2015).

Pooled referrals

A second notable feature of the SSI was the establishment of a centralized pooled patient-referral system or central intake model. Under a pooled-referral system, rather than directly referring patients to a particular specialist, family doctors list patients in a centralized surgical registry, who are then referred to the next available specialist in their jurisdiction with the shortest wait time. This approach aims to shorten delays for patients by recognizing that wait times for both consultations and procedures can vary considerably among specialists for the same procedure in the same region. Saskatchewan’s Referral Management Service (RMS) project was developed by Healthline Saskatchewan and was inspired by the examples of Ontario Cardiac Care Network, as well as the United Kingdom’s National Health Service (Government of Saskatchewan, 2012, 2013).

Saskatchewan’s RMS had two main components: [1] a province-wide standardized set of criteria for the assessment and prioritization of patients looking to get on a waiting list; and [2] a “pooled referral” system whereby groups of specialists in each region either working together or working independently agreed to have their referrals pooled. Patients retained the opportunity to search for and choose the specialist they desired or accept the first available specialist in the pool after reviewing the estimated wait times for treatment associated with different specialists online. By 2012, eight groups of specialists had adopted a pooled patient-referral system (Government of Saskatchewan, 2012), and by the end of 2014, this had expanded to 16 specialist groups representing 109 specialists (Duncan, 2015).¹²

12 The Referral Management Service is still operating in the province, with 11 specialist groups accepting referrals through the RMS. Other physician groups have chosen a pooled model but operate outside RMS. (eHealth Saskatchewan, nd).

The Saskatchewan Surgical Initiative and Patients Waiting for Surgery

Data from the provincial government's *Year 4 Report* (Duncan, 2014) reveal a clear reduction in the number of patients enduring extended wait times during the course of the SSI. At the start of the surgical initiative, there were 15,352 patients waiting more than three months. By the end, 3,824 patients were waiting longer than three months, a 75% reduction from March 2010 to March 2014 in the number of patients waiting longer than three months for surgery. During the same period, there was a reduction of 84% in the number of patients waiting more than six months.

It is useful to examine this data over a longer time frame to assess whether the decrease in wait times from 2010 to 2014 commenced prior to this period. More recent data from the provincial government and the Fraser Institute also helps us understand what happened to wait times following the conclusion of the SSI.

For purposes of analysis, the relevant data (depending on availability) are generally grouped in 5-year intervals that roughly correspond with significant shifts in policy discussed above. The time periods are the following.

1995–2000: Concern about wait times was growing throughout this period, while provincial governments were beginning take meaningful, concrete action to address increasing delays in the health-care system.

2000–2005: The Task Team on Surgical Waiting Lists was established in 1998 and Saskatchewan joined the Western Canada Waiting List Project in 1999. The effects of these would likely be realized during this period.

2005–2010: The pan-Canadian Health Accord was signed in 2004. The impact of additional funding and national benchmarks should begin to manifest during this period.

2010–2015: This period largely encompasses the SSI. However, it might also encompass the impact of additional funding tied to the 2004 Health Accord.

2015–2020: The SSI formally ended in 2014, as did the Canada Health Accord, though the federal government promised an extension of the annual 6% increase in transfer payments until 2016/17, after which the rate of increase was set by a three-year moving average of nominal economic growth, with a minimum 3% annual increase guaranteed regardless of the state of the economy.

Monthly data on the number of patients waiting beyond the governmentally defined benchmarks (3, 6, 12 and 18 months) between booking and treatment are available from the provincial government’s website from 2005 (Government of Saskatchewan, 2024). The percentage change in the number of patients waiting for the five years before, during, and after the SSI are presented in **table 1**.

Table 1: Change (%) in the number of patients waiting for treatment in Saskatchewan, 2005–2020

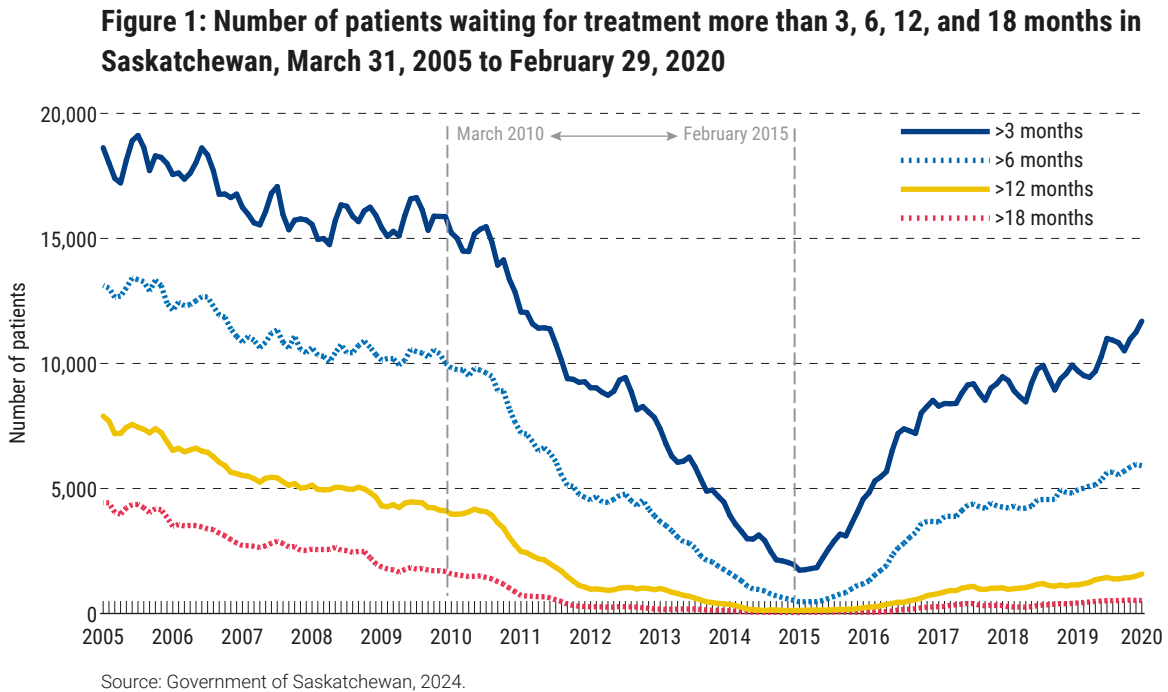
	> 3 Months	> 6 Months	> 12 Months	> 18 Months
March 2005–February 2010	-15%	-24%	-48%	-62%
March 2010–February 2015	-87%	-95%	-97%	-97%
March 2015–February 2020	575%	1,171%	1,185%	1,198%

Sources: Government of Saskatchewan, 2024; calculations by authors.

A review of data from the Government of Saskatchewan finds that the number of patients waiting more than three months fell 15% between 2005 and 2010, with extended delays of six months or more being reduced by between 24% and 62%. During the five-year period that roughly corresponds to the SSI, the number of patients waiting longer than three months fell by 87%, and the number with extended delays longer than 6 months fell between 95% and 97%. After the SSI ended, there was a 575% increase in the number of patients waiting over three months and an increase of nearly 1,200% in the number of patients waiting more than six, 12, and 18 months. In summary, while the number of patients facing extended delays did fall in the period immediately preceding the SSI, the rate of reduction accelerated substantially during the SSI period. That declining trend was reversed in subsequent years, with a significant increase in the number of patients facing extended delays for treatment (**figure 1**).

A similar pattern is observed in provincially reported wait-time data for the 90th percentile wait time, the number of weeks within which 90% of patients were treated.¹³ Over the five-year period preceding the SSI (March 2005 to February 2010), the number of days within which

13 The 90th percentile wait time, or the time within which 90% of patients are treated, is a commonly reported metric across Canada. Provincial data in Saskatchewan are available for the number of patients waiting longer than the 3-, 6-, 12-, and 18-month benchmark times, as well as for the 50th percentile (median) and 90th percentile wait times.



90% of patients received treatment fell by 14% (table 2; figure 2). An accelerated reduction can be observed during the SSI period, with the 90th-percentile wait time falling by 68%; in the post-SSI period, the 90th-percentile wait time grew by 117%.

A similar change in the median wait time, the number of weeks within which half of the patients were treated,¹⁴ during the SSI period is clearly observable, although the improvement is much smaller (table 2; figure 3). The median wait from booking to treatment fell from 49 days in March 2010 to 28 days in February 2015. However, unlike the 90th-percentile wait time, the median wait time grew by 22% in the pre-SSI period, suggesting that reduced wait times for long-wait patients prior to the SSI were accomplished through a general lengthening of wait times for all patients. As is the case for other wait-times measures, the median wait time increased by 34% in the post SSI period.

Waiting Your Turn, the Fraser Institute's annual survey of wait times, provides independent verification of these wait-time trends and also provides insight over a longer period of time (Moir and Barua, 2022, 2023). It also captures more of the total wait-time period than does governmental data. Specifically, the Saskatchewan government's wait-time data discussed above

14 The median wait time, or time within which half of patients were treated, can be understood as an estimate of the typical patient experience, or the delay a patient could typically expect. The 90th-percentile wait time can be understood as an estimate of the maximum amount of time a patient could expect to wait for health care. Wait-times distributions tend to have long tails, with a very small number of patients waiting extended periods of time relative to the typical patient. These wait times may not be relevant to understanding the typical patient's experience.

Table 2: Change (%) in median and 90th percentile wait times in Saskatchewan, 2005–2020

	50 th percentile (median)	90 th percentile
March 2005–February 2010	22%	-14%
March 2010–February 2015	-43%	-68%
March 2015–February 2020	34%	117%

Sources: Government of Saskatchewan, 2024; calculations by authors.

Figure 2: 90th percentile wait time in Saskatchewan, March 2005 to February 2020

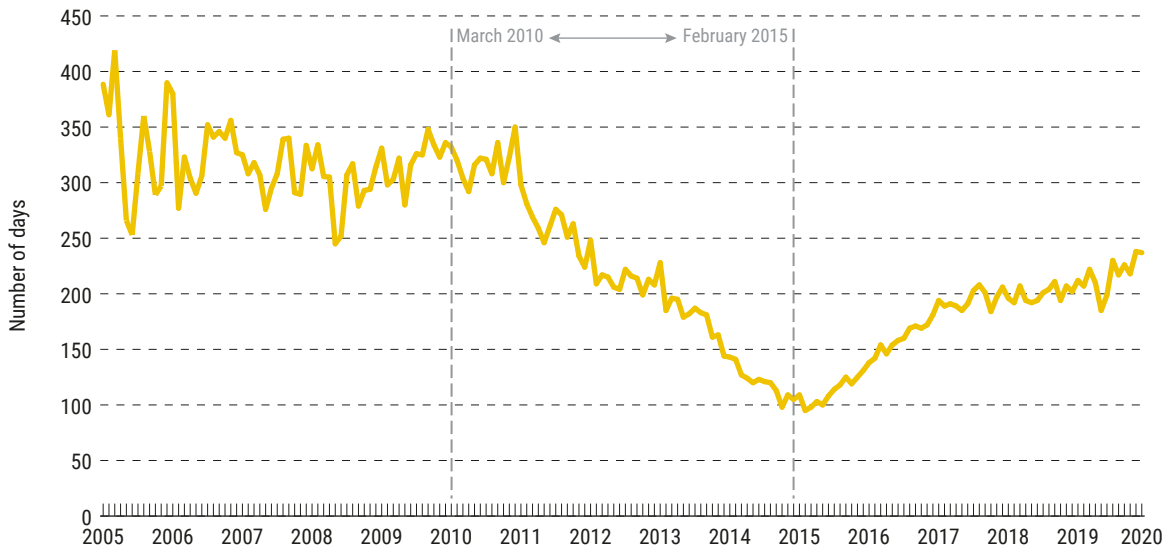
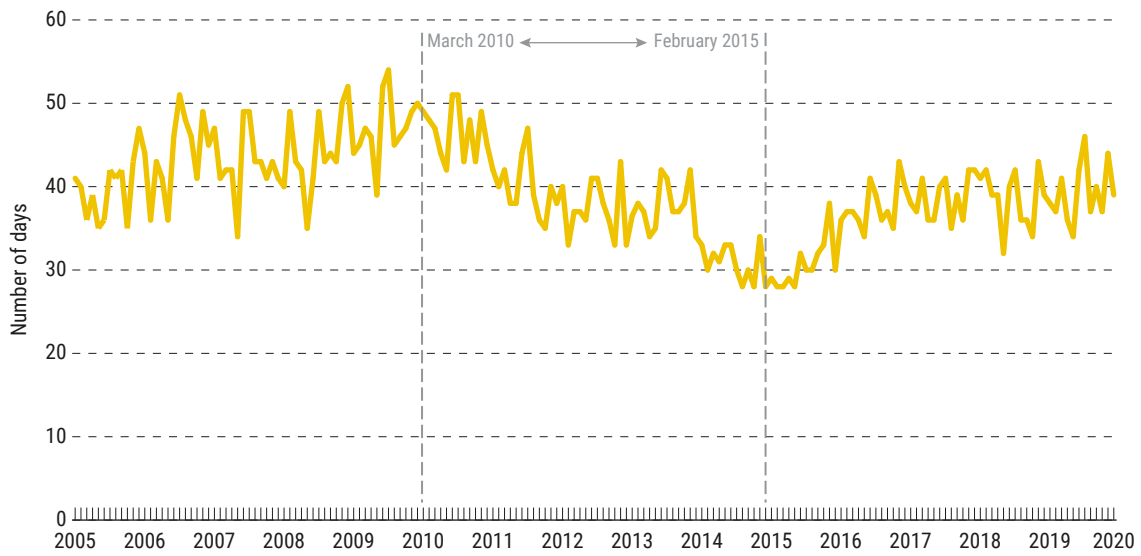
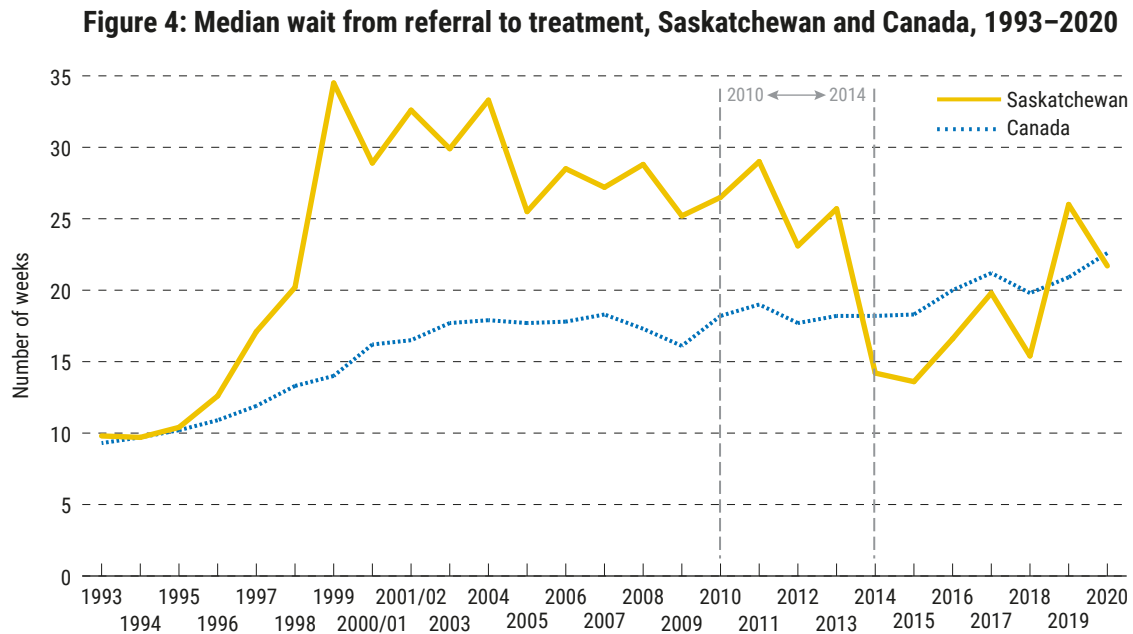


Figure 3: 50th percentile (median) wait time in Saskatchewan, March 2005 to February 2020



only starts counting wait times from when operating-room booking information for each new patient is received by the hospital. The Fraser Institute’s survey reports the wait between referral by a general practitioner to treatment by a specialist, capturing more of the delay imposed on patients in their health-care journey.

Looking specifically at the SSI period, in 2010 patients in Saskatchewan faced a median wait of 26.5 weeks between referral to treatment by a general practitioner to treatment. By 2014, the median wait at 14.2 weeks was the second shortest total wait time in Canada, having fallen 47% in the intervening years (figure 4; table 3). The decline during this period in Saskatchewan contrasted sharply with the Canadian average which, despite some movement in the intervening years, was essentially unchanged at 18.2 weeks in both 2010 and 2014 (Moir and Barua, 2023).



Examining the wait times in the periods before and after the SSI is again helpful in assessing the changes in patient experience during the SSI. The median wait time for treatment in Saskatchewan increased 232% between 1995 and 1999, and a further 15% between 2000¹⁵ and 2004, with a substantial improvement between 1990 and 2000 (figure 4; table 3). Wait times were fairly stable in the five years immediately preceding the SSI, and then declined by 47% in the five years roughly corresponding to the SSI. Wait times then increased 91% in the post-SSI period.

15 The Fraser Institute’s wait-time series is annual from 1993 to the present except for 2000–2002, for which only two measurements are available (2000/01 and 2001/02). Data from 2000/01 is used for 2000 in table 3.

In summary, wait-time data from both the provincial government and independent measurements by the Fraser Institute show that wait times declined very modestly over the five years preceding the SSI. However, wait times fell considerably over the five-year period that roughly corresponds to the SSI. After this period, wait times increased substantially.

Table 3: Change (%) in median wait from referral to treatment in Saskatchewan, 1995–2019

Change (%) in median wait		Change (%) in median wait	
1995–1999	232%	2010–2014	-47%
2000–2004	15%	2015–2019	91%
2005–2009	-1%		

Sources: Moir and Barua, 2023; calculations by authors.

Assessing the Wait-Time Data

While the previous section clearly identifies a significant reduction in wait times during the Saskatchewan Surgical Initiative, there remains the question of the specific role played by private providers in this achievement. As mentioned earlier, the SSI was a multi-pronged initiative. While it is difficult to empirically quantify the contribution of each of the individual features of the SSI, available data on provincial government spending, volume of services, and number of surgeries provided by third-party clinics provide some insight into the specific contribution of private providers.

Broadly, the available data allow us to address the following three questions:

1. How did spending change during the SSI?
2. Did the various actions of the SSI translate into services delivered?
3. What was the role of publicly funded third-party clinics relative to the public system, more generally?

Spending

An obvious question is whether the documented reduction in wait times during the SSI period (2010–2014) was simply a consequence of increased health-care spending. **Table 4** contains the total change in provincial government-sector per-capita health expenditure in Saskatchewan adjusted for inflation over each five-year period, as well as the average annual growth in this spending for each of the five-year periods identified earlier. Also included is the change in inflation-adjusted provincial spending per capita on hospital operating rooms for the years for which data are available.¹⁶

On average, there has been positive spending growth in four of the five periods examined. Notably however, the average annual rate of growth in spending for the period roughly corresponding to the SSI is lower than the growth rate in the three previous five-year periods, both

16 Population data is from Appendix D.1 and the Consumer Price Index from Appendix B.2 of the Canadian Institute for Health Information's national health expenditure data tables (CIHI, 2023a).

Table 4: Change (%) in per-capita, inflation-adjusted (\$1997 constant dollars) spending, in Saskatchewan, 1995–2019

	Total change in provincial health-care spending	Average annual change in provincial health-care spending	Total change in provincial spending on hospital operating rooms
1995–1999	14.1%	2.5%	data not available
2000–2004	17.1%	3.6%	data not available
2005–2009	9.1%	3.0%	22.7%
2010–2014	0.8%	0.8%	0.4%
2015–2019	-0.1%	-0.1%	-3.1%

Sources: CIHI, 2023a: table B.4.8; CIHI, 2023b: table B.8.1; calculations by authors.

for overall health expenditures and for spending on hospital operating rooms specifically. This suggests that spending alone is unlikely to explain the accelerated reductions in wait times during the SSI period. On the other hand, the leveling off of inflation-adjusted per-capita provincial health-care spending between 2015 and 2019, which includes a decline in spending on hospital operating rooms and a shift to other areas of expenditure, does coincide with a period of notable increases in wait times following the SSI.¹⁷

A recent report suggests: “Wait-time reductions during the Saskatchewan Surgical Initiative relied on a significant short-term injection of funding to expand public sector surgical capacity. Public hospital operating room funding steadily climbed from \$129 per capita in 2009–2010 to \$158 per capita in 2013–2014” (Longhurst, 2023: 12). However, these figures do not account for inflation. After adjusting for inflation, real per-capita spending on public hospital operating rooms was indeed lower in the five years preceding the SSI, as well as the five years after. The greatest increase in inflation-adjusted spending per capita on public hospital operating rooms, however, was observed in the five years preceding the SSI, with minimal growth during the initiative, and a decline afterwards (table 4). It is also notable that in 2015, when wait times in Saskatchewan were the lowest in the country, inflation-adjusted spending per capita on public hospital operating rooms was actually lower than in 2009 (the year immediately preceding the SSI), while hospital spending in the last year of the SSI was only 1.3% above the 2009 level.

To be sure, the SSI was not a costless initiative. The government of Saskatchewan cumulatively invested approximately \$235 million in the SSI to remove bottlenecks and reduce wait times between 2010 and 2015 (Second Street, 2022). During the same period, MacKinnon (2016)

17 As seen below, this reduction in spending on hospital operating rooms coincides with a period of stabilization in surgical volumes in public hospitals.

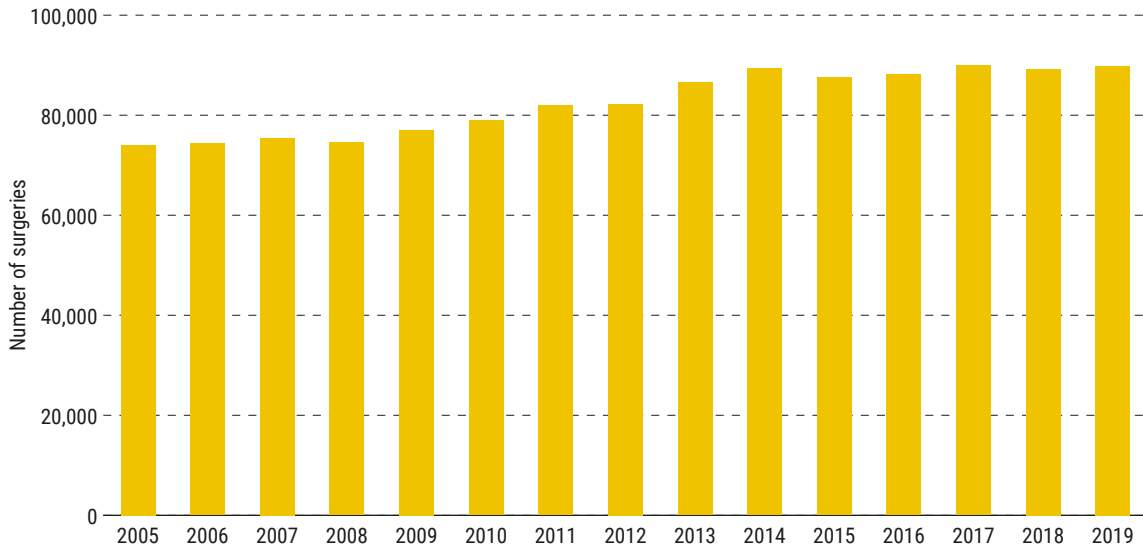
reports that \$236.5 million was invested in surgical services. Mackinnon also finds, however, that for 2012 “the total cost of performing the 34 procedures in [private] clinics was 26% less than the cost would have been had the procedures been performed in the hospital” (2016: 28). A more recent analysis provided by the government of Saskatchewan, using a methodology developed by the Canadian Institute for Health Information, showed per-procedure costs in private surgical centers were between 35% and 45% lower than in public hospitals, though this could be partially explained by the reality that clinics typically serve patients with less complex conditions and requiring no overnight or extended recovery costs (Second Street, 2022).

The evidence suggests, therefore, that the SSI’s success in reducing wait times is unlikely to be purely a function of increases in government spending. While spending increased in Saskatchewan alongside improvements in wait times during the SSI, higher rates of growth in spending both in total and for operating rooms specifically were observed alongside lower rates of improvement prior to the SSI. It is also well understood that increases in spending generally across Canada have not been able to reduce delays in access to health care in other provinces. Hence, the SSI arguably improved the efficiency with which health-care dollars were spent procuring services for patients through private contracting at a lower cost than had been realized in public hospitals.

Surgical volume

A second question of interest is whether the various actions of the provincial government (including money spent) translated into an increase in services delivered. Indeed, the primary objective of the SSI’s decision to subcontract surgical services from private providers was to reduce wait times by increasing surgical volumes above what was possible through public facilities. Governmental data confirm a clear increase in the volume of surgeries performed during the SSI, and a plateauing in subsequent years (**figure 5**). The reported data show that the total annual volume of surgeries performed increased from 78,960 in 2010 to 89,333 in 2014, an increase of 13%. Since, as we saw above, inflation-adjusted per-capita expenditures during the SSI period were relatively stable, the data reported in table 5 suggest that there were increases in efficiency associated with contracting out during the SSI period.

Looking again at a longer time period, the average number of surgeries performed annually increased by 4% over the five years preceding the SSI, by 13.1% during the five years roughly corresponding to the SSI, and by 2.6% in the subsequent five-year period (following a 2% drop in volume between the SSI and post-SSI periods) (**table 5**). In other words, the average annual volume of surgeries increased over the 15-year period from 2005 to 2019, but the fastest rate of growth corresponds to the five-year period associated with the SSI. Adjusting the volume of

Figure 5: Total number of surgeries performed in Saskatchewan, 2005–2019

Source: Personal correspondence, Government of Saskatchewan (August 29, 2023).

Table 5: Volume of surgeries in Saskatchewan, 2005–2019

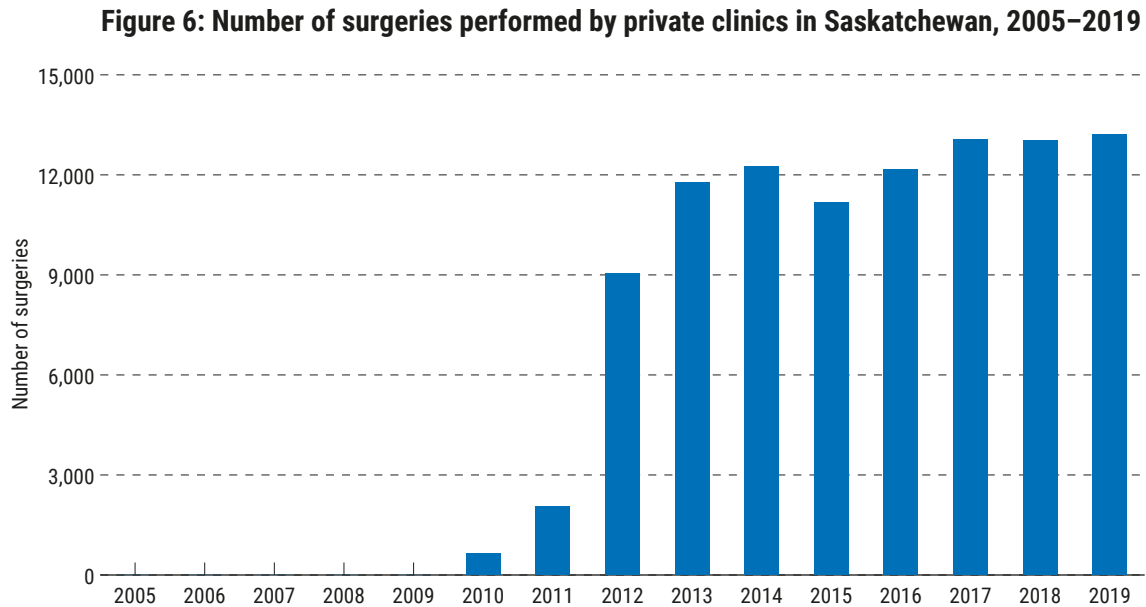
	Average number of surgeries	Total change over period	Total change per thousand population over period
2005–2009	75,091	4.0%	-0.1%
2010–2014	83,789	13.1%	6.9%
2015–2019	88,952	2.6%	-1.9%

Sources: CIHI, 2023a; Government of Saskatchewan, 2024; calculations by authors.

procedures for changes in population does not alter this conclusion: the number of surgeries per thousand population in the five years preceding the SSI remained approximately constant, while the five years roughly corresponding to the SSI saw a 6.9% increase, and the subsequent five years saw a 1.9% decrease.

Delivery by third-party private clinics

Until the SSI was established, there was no significant volume of publicly funded, medically necessary services contracted to third-party private clinics in Saskatchewan (Allin *et al.*, 2020). As can be seen in figure 6, there was a large increase in the number of publicly funded surgeries performed



Source: Personal correspondence, Government of Saskatchewan (August 29, 2023).

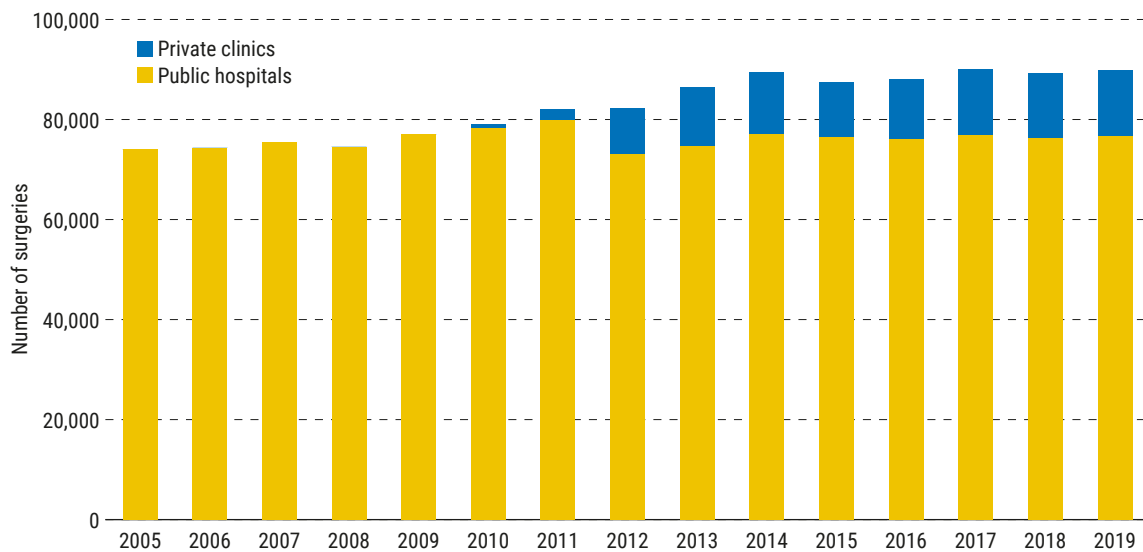
by third-party private clinics during the period of the SSI. There was also a shift towards private activity with a decline in total activity in public hospitals in 2012 and 2013 that was roughly restored to pre-SSI levels in 2014. The SSI period was followed by a plateauing of surgical volumes in both public hospitals and private clinics, with a small additional shift to increased participation for private clinics (table 6; figure 7).

Private clinics clearly played a significant role in the delivery of services during the SSI period as the government found itself challenged to increase surgical volumes and reduce very long waits. Private clinics have also continued to support the delivery of universally accessible services afterwards, although the largely stable total surgical volumes do help to explain the increase in wait times experienced in Saskatchewan in the post-SSI period, when the population of Saskatchewan has been both growing and ageing and thus increasing the demand for health care.

Table 6: Distribution of surgeries in Saskatchewan, 2005–2019

	Surgeries in public hospitals	Surgeries in private clinics	Total	Share provided in the private clinics
2005	74,088	0	74,088	0.0%
2006	74,320	0	74,320	0.0%
2007	75,396	0	75,396	0.0%
2008	74,563	0	74,563	0.0%
2009	77,086	0	77,086	0.0%
2010	78,323	637	78,960	0.8%
2011	79,914	2,050	81,964	2.5%
2012	73,153	9,028	82,181	11.0%
2013	74,727	11,781	86,508	13.6%
2014	77,073	12,260	89,333	13.7%
2015	76,387	11,157	87,544	12.7%
2016	76,000	12,172	88,172	13.8%
2017	76,903	13,072	89,975	14.5%
2018	76,194	13,038	89,232	14.6%
2019	76,612	13,225	89,837	14.7%

Source: Personal Correspondence, Government of Saskatchewan (August 29, 2023)..

Figure 7: Total number of procedures performed in Saskatchewan, by provider type, 2005–2019

Sources: Personal correspondence, Government of Saskatchewan (August 29, 2023); calculations by authors.

Discussion and Concluding Comments

At a time when provinces across Canada are dealing with significant backlogs for surgical treatments, and with many reporting unprecedented wait times, it is more important than ever to consider potential reforms based on strategies with documented success, such as the Saskatchewan Surgical Initiative (SSI). However, ten years after the conclusion of the SSI, the lessons learned are at risk of being forgotten. This study revisits key aspects of the SSI with a specific focus on the role of private clinics in providing publicly funded surgical care.

In our review of the five-year period (2010 to 2015) associated with the SSI, governmental data indicate an 87% reduction in the number of patients waiting longer than three months for surgery and a 95% reduction in the number of patients waiting more than six months. The median wait, from booking to treatment, fell from 49 days in March 2010 to 29 days in March 2015, while the 90th percentile wait fell from 332 days to a still long but substantially improved 109 days. Independent estimates of wait times from the Fraser Institute confirm the substantial improvement in the delays patients had been experiencing in Saskatchewan. Specifically, Fraser Institute data show that the median wait from referral to treatment fell from 26.5 weeks in 2010 to 14.2 weeks by 2014, a 47% reduction that saw Saskatchewan move from one of the provinces with the longest wait times to among those with the shortest total wait times that year. By 2015, immediately following the conclusion of the SSI, wait times fell further to 13.6 weeks, the shortest total wait time recorded in any province that year.

Unfortunately for residents of Saskatchewan, these gains were largely lost in the years following the SSI. It is important to recognize that the SSI did not change the fundamental structure of the Medicare program and its key characteristics of governmental insurance with first dollar coverage and no cost sharing, and non-competitive delivery of universally accessible hospital and surgical services. Indeed, it has been noted in an OECD compendium on wait-times policies that “[l]ong waiting times for elective treatments generally tend to be found in countries that combine public health insurance with zero or low patient cost sharing and constraints on capacity ... [and] are found less often in countries with social insurance that allow choice of provider” (Siciliani, Borowitz, and Moran, 2013: 11). The shift towards private delivery and central pooling along with other bureaucratic initiatives to eliminate bottlenecks did meaningfully shrink the delays experienced by patients in Saskatchewan’s health-care system, but they did not alter the fundamental characteristics that generated the long delays in the first place.

In a similar vein, while the SSI was able to take advantage of the efficiencies that come with an increase in the use of private-sector contractors, the governmental restrictions placed on private providers limited the benefits realized by patients and taxpayers. By restricting private clinics to performing only publicly funded services, the government suppressed the opportunity those facilities might have had to further increase total surgical volumes by seeing privately funded patients beyond those treated with public funding. Private facilities proved their ability to attract workers who were unable or unwilling to work in the government system by offering more flexible employment arrangements. They also proved their ability to satisfy patients by providing attractive and comfortable settings (MacKinnon, 2016). Freed from the restriction on accepting private insurance or out-of-pocket payments, private clinics would have had an incentive to recruit underemployed physicians in the province or use physician services more intensively by paying more to physicians willing to work longer hours for increased remuneration. Such actions would have enabled private clinics to provide additional surgeries beyond the volumes contracted by government.

The SSI also failed to take full advantage of private-sector efficiency by maintaining government controls on patient intake through health regions and by the use of contracts assigning volumes and setting prices rather than by having payments follow patients freely to the facility of their choosing, including both private and public facilities. Successful wait-times initiatives in countries such as the United Kingdom, Portugal, and Denmark all included free choice of provider alongside wait-time targets and sanctions (in some cases only after a benchmark wait time was exceeded). Free choice of provider is also a central characteristic of universal-access health-care systems without wait times (Borowitz and Moran, 2013). Having money follow patients to the facility of their choosing can meaningfully shift the health-care system towards adopting a more patient-focused approach, including reducing wait times, improving quality of care, and adopting new medical technologies and best practices alongside other initiatives to improve cost efficiency (Esmail, 2021).

What the SSI does clearly demonstrate is that, even in a limited and restricted setting, private for-profit clinics can have a positive and significant impact on the patient experience and can serve as a vital partner in wait-time reduction strategies. This finding from the SSI is consistent with conclusions drawn from experiences with elective surgical outsourcing in other countries (Cooper, Gibbons and Skeltern, 2018; Rathnayake, Clarke and Jayasinghe, 2022; Duong, 2023). Specifically, studies generally report that private provision of publicly funded surgical services increases surgery volumes and reduces pre-surgery waiting times.¹⁸

18 It should be acknowledged that a number of the relevant studies also conclude that private clinics tended to take on healthier patients, although this should not be perceived necessarily as a negative outcome. Allowing specialization and the creation of smaller hospitals focused on less complex cases may, in fact, provide additional benefits. Having acute-care hospitals (public or private) focus on more medically difficult cases while leaving medically easier cases to specialty clinics may be a superior arrangement to having all patients (no matter their

Perhaps the most concise summation on the value of the SSI is provided by Janice MacKinnon, in the conclusion to her report:

The SSI was successful within a specific context. It only improved wait times for elective surgery; long waits remain in other areas. It also involved increasing capacity, which meant pouring more money into an already expensive health-care system. Finally, it did not tackle the structural problems of Medicare that foster long wait times. The SSI treated the symptom—the waiting lists—rather than the root problem: Medicare’s structure and funding. But it was not designed to fix Medicare. Its goal was to relieve the suffering of patients who were waiting far too long for surgery. In that it succeeded. (MacKinnon, 2016: 34)

In conclusion, the Saskatchewan’s experience with the SSI suggests that publicly funded surgeries outsourced to private clinics can serve as a beneficial first step on the road to reform, with a significant increase in volumes and a commensurate reduction in wait times clearly associated with this expansion in at least the early stages. Provinces across Canada struggling with significant backlogs for surgical treatments and overlong wait times would be well advised to take note of Saskatchewan’s approach, which very successfully reduced wait times in that province over its short period of operation. The benefit of emulating this approach, if not adopting an enhanced and bolder version of it, would be more timely access to care for patients with better value provided for taxpayer dollars.

level of medical complexity) treated in full-service facilities (Ruseski, 2009). Competition between the two for patients can also be beneficial. A central challenge for governments is to ensure that the care provided to more complex patients is remunerated appropriately so that full-service hospitals do not need to rely on financial cross-subsidization from care provided to less complex patients, and that remuneration for less complex patients appropriately reflects the lower cost of caring for them (particularly in specialized clinics focused on routine, less risky procedures with accompanying lower capital costs).

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Our mission is to improve the quality of life for Canadians, their families and future generations by studying, measuring and broadly communicating the effects of government policies, entrepreneurship and choice on their well-being.

Notre mission consiste à améliorer la qualité de vie des Canadiens et des générations à venir en étudiant, en mesurant et en diffusant les effets des politiques gouvernementales, de l'entrepreneuriat et des choix sur leur bien-être.

Peer review—validating the accuracy of our research

The Fraser Institute maintains a rigorous peer review process for its research. New research, major research projects, and substantively modified research conducted by the Fraser Institute are reviewed by experts with a recognized expertise in the topic area being addressed. Whenever possible, external review is a blind process. Updates to previously reviewed research or new editions of previously reviewed research are not reviewed unless the update includes substantive or material changes in the methodology.

The review process is overseen by the directors of the Institute’s research departments who are responsible for ensuring all research published by the Institute passes through the appropriate peer review. If a dispute about the recommendations of the reviewers should arise during the Institute’s peer review process, the Institute has an Editorial Advisory Board, a panel of scholars from Canada, the United States, and Europe to whom it can turn for help in resolving the dispute.

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