

April 2016
Fraser Institute

Learning from the Saskatchewan Surgical Initiative to Improve Wait Times in Canada

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Executive Summary

Wait times for elective surgery are long in Canada relative to other OECD countries and Saskatchewan has historically had among the longest of all the provinces. In 2010, the Saskatchewan government announced the Saskatchewan Surgical Initiative (SSI) to tackle wait times and promised that by 2014 no patient would wait more than three months for surgery. Today Saskatchewan's wait times for elective surgery are among the shortest in Canada. What explains Canada's long waiting lists, what prompted governments to tackle them, and why was Saskatchewan successful in reducing them?

Canada's long waiting lists are related to the funding and structure of Medicare. Governments' reluctance to change Medicare's funding and structure helps to explain their slow response to wait times. Also, waiting lists primarily affected patients: as reports on health care demonstrated, the health care system was dominated by those providing care and was not centred on patients.

Pressure to act came in the 1990s when the Fraser Institute began tracking Canada's growing waiting lists and patients went public with stories about their suffering while waiting for treatment. The Supreme Court's 2005 decision in the *Chaoulli* case also put pressure on governments: its main message was that, if governments impose a monopoly on medical services, then they have to deliver those services in a timely way.

In developing the SSI, Saskatchewan worked with, and learned from, other provinces—belying the image of a fragmented health-care system in which leadership must come from the federal government—and built upon previous Saskatchewan initiatives to reduce waiting lists. The SSI changed the way waiting lists were managed and organized, but it also fundamentally changed the culture and decision-making process in health care.

The 2015 Report of the Advisory Panel on Healthcare Innovation written for Health Canada cited three factors that drive innovation in health care and all three were central to the SSI. One factor was leadership: in setting a firm and specific target to reduce wait times the government provided the leadership and vision that drove the SSI. The second factor was the engagement of front-line staff in embracing change, which was achieved in the SSI by developing a more collaborative and inclusive decision-making process. The third factor was the SSI's patient-centred focus, a fundamental change in a system that had historically been dominated by providers. Effective communications with the public was also a central feature of the SSI and a major reason for its success.

Effective communications also helps to explain the success of the most controversial aspect of the SSI, the use of private, for-profit clinics to deliver day-surgery procedures. Health-care unions and self-styled defenders of

Medicare warned the public that the private clinics would threaten the core values of Medicare. The transparency and accountability in the process of selecting the companies to run the clinics and regulating their operations were important in blunting criticisms. Also, though the government saved money by having procedures performed in the clinics rather than in hospitals, this fact was downplayed in the communications, which focused on the patients and their need for timely care. Most important, however, was the message that the clinics would help to reduce wait times. After years of living with long waits for treatment, people in Saskatchewan were prepared to set aside ideology and willing to judge the clinics on their results.

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.

Introduction

The Supreme Court of Canada’s 2005 decision in the *Chaoulli* case [1] raised the profile of, and legitimized, long-standing concerns about wait times and their effects on patients’ health. The decision came less than a year after the federal and provincial governments agreed to a 10-year Health Accord, [2] in which the federal government provided funding to reduce wait times in five priority areas [3] and the provinces committed to establish evidence-based benchmarks for medically acceptable waits. In the Supreme Court’s decision, the majority took seriously the testimony that patient health was being compromised by lengthy wait times, which were described as having “serious, sometimes grave, consequences”. [4] The case marked a turning point in Canadian health-care policy since it focused on patients and their right to timely treatment. It was an important message about a health-care system dominated by powerful stakeholders and interest groups. In his 2009 review of Saskatchewan’s health-care system, Tony Dagnone stated “our current health-care system has been designed around the people who deliver the care” not those receiving it, and his report was aptly titled *Patient First*. [5] Another effect of the decision was to stress the need for governments to be accountable for reducing wait times. The majority decision essentially told governments that, if they impose a monopoly on hospital and doctor services, then they have to be accountable for delivering those services in a timely way. [6] In his report, Dagnone pronounced that “Access delayed is access denied”. [7] Accountability came to mean governments setting targets for acceptable wait times and then working to meeting those targets to the satisfaction of citizens.

The themes of accountability and focusing on patients were reflected in the Saskatchewan Surgical Initiative (SSI), established by the government in 2010 to reduce wait times and implement key recommendations of the *Patient First* report. Taking on the challenge of reducing wait times was

[1] *Chaoulli v. Quebec (Attorney General)*, 2005 SCC.

[2] Health Canada (2014), *First Ministers’ Meeting on the Future of Health Care* (September 16).

[3] Health Canada (2014), *First Ministers Meeting*: the five areas were cancer treatment, heart procedures, diagnostic imaging, joint replacement, and sight restoration.

[4] *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, McLachlin C.J & Bastarache J.J. par. 112.

[5] Tony Dagnone (2009), *For Patients’ Sake: Patient First Review Commissioner’s Report to the Saskatchewan Ministry of Health* (October): 3.

[6] Patrick Monahan (2006), *Chaoulli v Quebec* and the Future of Canadian Healthcare: Patient Accountability as the “Sixth Principle” of the Canada Health Act, 2006 Benefactors Lecture, C.D. Howe Institute.

[7] Dagnone (2009), *For Patients’ Sake*: 27.

a major undertaking for the Saskatchewan government. Since the 1990s, the Fraser Institute's annual study, *Waiting Your Turn: Wait Times for Health Care in Canada*, [8] consistently showed that Saskatchewan had some of the longest wait times in the country. In 2010, with a population of about one million, Saskatchewan had 27,500 patients waiting for surgery, with an estimated one in five waiting for more than a year and some waiting two years. [9]

The guiding principle of the SSI was the target that by March 2014 no patient would wait more than three months for surgery. In March 2014, the government declared victory when it announced that there had been a 75% reduction in patients waiting more than three months for surgery. [10] Whether or not all patients awaiting surgery were treated within three months is debatable. What is clear is that by 2014 there was a dramatic reduction in wait times and the vast majority of patients received their surgery within three months.

What factors explain the success of the SSI? After years of pouring money into the health-care system with little reduction in wait times, how did the Saskatchewan government find a process that seemed to work? A central theme of the SSI was focusing on the patient, which meant that doctors and other health professionals had to change the way they operated. Yet a major obstacle to implementing health-care reform in Canada has been the dominance of powerful stakeholders, such as doctors, nurses, and powerful health-care unions, and their resistance to change that adversely affects their members. How, then, did the SSI implement fundamental changes without significant opposition from stakeholder groups? Finally, the most controversial aspect of the SSI was the introduction of private, for-profit clinics to deliver publicly funded health-care services. How did the government persuade the public that private, for-profit clinics were not at odds with the principles of the much-prized health-care system introduced in Saskatchewan by Tommy Douglas?

Overview

The study begins looking at wait times in Canada by highlighting the main messages in the *Chaoulli* decision about Canada's health-care system and waiting lists and the reluctance of governments to tackle the problem. It also considers why Canada has such long waiting lists relative to other OECD countries. The conclusion is that the long wait lists are related to the way that Medicare was funded and structured. However, since Canadian governments

[8] Various authors (1990–2015), *Waiting Your Turn: Wait Times for Health Care in Canada*, <www.fraserinstitute.org>.

[9] Minister Dustin Duncan (2014), *Saskatchewan Surgical Initiative* (March 31). Saskatchewan Surgical Initiative. <<http://www.sasksurgery.ca/pdf/sksi-year4-report.pdf>>.

[10] Duncan (2014), *Saskatchewan Surgical Initiative*.

have been unwilling to make fundamental changes to Medicare's structure and funding, other policy tools, such as improved management, have been used to address wait times.

Pressure to address waiting lists came from the *Chaoulli* decision, research institute reports like the Fraser Institute's *Waiting Your Turn*, and high profile stories of patients' suffering. By the first decade of the 21st century, the Saskatchewan government began to tackle waiting lists by learning from other provinces and countries, and implementing changes to the management of the waiting lists.

The SSI, which was released in 2010, included several key components: targets or guarantees for wait times, a centralized registry for waiting lists with standard measures for prioritization, collaborative decision making, a patient-centered focus, and accountability. In effect, the SSI changed the culture of health care in the area of wait times and reflected the key ingredients cited by the 2015 Report of the Advisory Panel on Healthcare Innovation [11] as requirements for innovative change: leadership, engagement of front-line staff in decision making, and a patient-centered focus.

The most controversial aspect of the SSI was the use of private, for-profit clinics to increase the capacity of the health-care system. The final section of the study considers the challenges associated with convincing the public that the clinics were not at odds with the values of Medicare. The clinics were successful in part because of effective communication, which was one of the key elements in explaining why the public and stakeholders' groups accepted the SSI.

[11] Advisory Panel on Healthcare Innovation (2015), *Unleashing Innovation: Excellent Healthcare for Canada: Report of the Advisory Panel on Healthcare Innovation* (Health Canada): 36–37, <<http://www.healthycanadians.gc.ca/publications/health-system-systeme-sante/report-healthcare-innovation-rapport-soins/alt/report-healthcare-innovation-rapport-soins-eng.pdf>>.

Access to a Waiting List Is Not Access to Health Care

The comment made in the majority decision in the *Chaoulli* case that “access to a waiting list is not access to health care” captured the essence of the controversial Supreme Court decision. [12] The case involved a challenge to the power of the Quebec government to enforce its monopoly of Medicare services by preventing citizens from buying private health insurance for services covered by Medicare, while at the same time failing to deliver the services in a timely way. The majority decision was that

based on the evidence ... prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with the life and security of the person as protected by s. 7 of the Charter [of Rights and Freedoms]. [13]

Especially important for this study are the comments made by the Justices about wait times and Medicare that formed the basis for their legal opinion. The majority accepted the expert testimony that wait times, even for elective procedures, were a major problem in Canada’s health-care system that adversely affected patients’ health and well-being. The majority decision cited evidence that delays in orthopedic surgery led in some cases to “irreparable damage” to people’s health and that long waits for arthritis surgery caused pain and a diminished quality of life. [14] Expert testimony about the problems of those experiencing long waits for hip and knee replacements was also referenced. The judgement stated: “Even though death may not be an issue for them, these patients ‘are in pain’, ‘would not go a day without discomfort’ and are ‘limited in their ability to get around’, some being confined to wheel chairs or house bound”. [15] Other evidence was cited about the psychological damage caused by long waits for treatment and the fact that some patients suffered from anxiety and depression. [16]

[12] *Chaoulli*, par 123.

[13] *Chaoulli*, par. 124.

[14] *Chaoulli*, par. 42.

[15] *Chaoulli*, par. 114.

[16] *Chaoulli*, par. 116, par. 117.

The long waits for treatment in the Canadian system were also seen as being related to the way the system was structured and the policy choices made by governments. Justice Deschamps described waiting lists as “intentional” in the sense that governments had choices about the policies they adopted and she argued that they were a product of a “form of rationing”. The Chief Justice surveyed comparable health systems in other countries and found that others provided better services at a lower cost. She wrote: “Many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada”. [17]

Governments [18] were also chastised for their failure to reduce waiting lists. It was pointed out that the evidence on the negative effects of wait times was available, various commissions were established, and governments made promises to find a solution to wait times. However, the debates about wait times, it was argued by Justice Deschamps, focus on “a socio-political philosophy” and in the process governments have “lost sight of the urgency of taking concrete action”. In a stinging rebuke of governments for their inaction she wrote: “while the government has the power to decide what measures to adopt, it cannot choose to do nothing in the face of the violation of Quebeckers’ right to security”. [19]

The *Chaoulli* decision sets an appropriate context for an analysis of wait times in Canada and leads to some interesting questions. What is it about Medicare that leads to such long wait times for health-care treatment relative to comparable countries? Why have governments been so slow to respond to increasing wait times? What factors forced governments, like Saskatchewan, to address the issue of long wait times?

[17] *Chaoulli*, par. 39, par. 142, par. 143, par. 140.

[18] In this case the Government of Quebec.

[19] *Chaoulli*, par. 96, par. 97.

Wait Times in Canada

Evidence of the long wait times characteristic of Canada’s health-care system is not hard to find. For example, the 2012 Commonwealth Fund Survey ranked Canada last of 11 countries in timeliness of care. Long wait times were also documented by earlier studies, such as the 2004 Conference Board of Canada report, which benchmarked Canada’s health-care performance against 23 other OECD countries. The report stated that wait times are “already among the highest in OECD countries” and the biggest concern of Canadians. [20]

Also, by the first decade of the 21st century there was strong evidence that long wait times adversely affected patients in a variety of ways. A 1998 Health Canada study found that waiting lists “adversely affect” patients in terms of their quality of life and the stress associated with waiting for care. [21] A 2005 study of patients waiting for elective surgery concluded that long waits were associated with a “worsened long term prognosis”, pain, emotional distress, anxiety, frustration, anger, and depression. There was also evidence that long waits negatively affected patients’ social life, their work, and their perceptions of the health-care system. For instance, a study of parents whose children were waiting for surgery concluded that the long waits and the stress led to “their declining approval of the health care system”. [22]

There are many reasons that the structure and funding of Medicare results in longer wait times. A 2013 OECD study on wait times for elective treatments linked long wait times to “countries that combine public health insurance with zero or low patient cost-sharing and constraints on capacity”. [23] [24] When Medicare was created there was discussion about whether or

[20] C. Schoen and R. Osburn (2012), *The Commonwealth Fund 2012 International Health Policy Survey of Primary Care Physicians*, Commonwealth Fund; Conference Board of Canada (2004), *Understanding Health Care Cost Drivers and Escalators*, Conference Board of Canada (March): Executive Summary.

[21] Health Canada (1998), *Waiting Lists and Waiting Times for Health Care in Canada: More Management!! More Money??*, Government of Canada: 24.

[22] G.L.M. Hilkuysen, J.P. Oudhoff, M. Rietberg, G. van der Wall, and D.R.M. Timmermans (2005), Waiting for Elective Surgery: A Qualitative Analysis, *Public Health* 119, 4: 290-293; Grant G. Miller (2004), Waiting for an Operation: Parents’ Perspectives, *Journal of Surgery* 47, 3: 179–181; quotation at 179.

[23] L. Siciliani, L.M. Borowitz, and V. Moran, eds. (2013), *Waiting Time Policies in the Health Sector: What Works*, OECD: 11.

[24] See Nadeem Esmail (2013), *Understanding Differences in Wait Times*, in Steven Gliberman, ed., *Reducing Wait Times for Health Care: What Canada Can Learn from Theory and International Experience* (Fraser Institute): 119–156. Mr Esmail concluded that developed countries that manage to deliver universal access to care without queues generally “employ choice and competition in the delivery of services and require consumers to

not patients should be charged directly for health services. Earlier studies on social policy in Canada had assumed that the costs of Medicare would be borne by both the government and the individuals receiving the care. [25] Also, Tom Kent, Prime Minister Pearson’s main policy advisor when Medicare was established, recommended that 25% of the cost of the system be paid directly by patients through the income-tax system by making health care a taxable benefit. [26] His concern was that if there was no link between patients and the costs of the system, then there would be no restraint on demand for services. His advice was rejected. Hence, in the Medicare system, in which patients make no financial contribution to the cost of their care, there is no financial constraint on demand. Former Quebec Health Minister Claude Forget explained the problem well when he described Medicare as a “powerful engine and no brakes”. [27]

With no levers to control demand and a concrete limit to the resources available for governments to fund health care, Canadian governments have traditionally controlled costs by limiting capacity. Former Federal Finance Minister Don Mazankowski in his 2001 report on Alberta’s health-care system stated: “if we restrict ourselves to a system where all the funding comes from provincial and federal taxes we have little choice but to ration services”. [28] Government rationing means shortages of supply. It is not surprising, then, that compared to other OECD countries Canada has historically had fewer professionals and facilities and less equipment. In 2010, for example, Canada had 1.7 physicians per thousand population while the OECD average was 3.1; in 2009, Canada had 1.7 beds for curative care per thousand population while the OECD average was 3.4; Canada had 14.2 CT scanners per million population, while the OECD average was 22.6; and Canada had 8.2 MRIs per million population while the OECD average was 12.5. [29] Limited capacity and unlimited demand means people have to wait for access to services.

share in the costs of their health care ... employ a social insurance construct for the funding and operation of health care ... [resulting in] a clearer connection between the payment for services and the provision of those services” (2013: 149).

[25] Edmond Cloutier (1954), *Report of the Royal Commission on Dominion-Provincial Relations Book 1: Canada 1867– 1939*, Government of Canada. Leonard Marsh (1943), *Report on Social Security for Canada*, University of Toronto Press: 12–13.

[26] Janice MacKinnon (2005), Interview with Tom Kent (April 29), Kingston, Ontario. It should be noted that co-payments are a feature of many health-care systems that have universal access.

[27] Claude E. Forget (2002), *Comprehensiveness in Public Health Care: An Impediment to Effective Restructuring*, *IRRP Policy Matters*: 11.

[28] Don Mazankowski (2001), *A Framework for Reform: Report of the Premier’s Advisory Council on Health* (Edmonton: 2001), p. 4.

[29] Organisation for Economic Co-operation and Development [OECD] (2010), *OECD Economic Surveys: Canada*, OECD; OECD (2012), *OECD Health Data*, OECD.

Another factor linked to wait times for surgery is the deep but not broad coverage of Medicare, which provides 100% coverage for doctor and hospital services but provides only limited funds for services and programs that would prevent disease in the first place. It also fails to cover alternatives to hospital care, such as long-term care or home care, which are less expensive than hospitals. This is in contrast to other OECD countries where a broader range of services are covered and partially paid for by user fees or co-payments. In Canada, while patients are in hospital their services and drugs are paid for; however, once they leave hospital for a long-term care facility or use home care, they have to pay at least part of the cost of their care. The incentive is to stay in hospital, a problem that is worsened by the shortage of facilities offering alternative care. In its 2015 report, the Wait Time Alliance, a group of health-care professionals concerned about wait times, stated that procedures, like elective surgeries were often cancelled due to a lack of hospital beds since “patients who no longer require acute care continue to occupy hospital beds because of a lack of access to more appropriate community based resources such as their home (with the necessary supports) or a residential care facility”. [30]

Another key decision made when Medicare was created was to pay doctors on a fee-for-service basis—rather than following the practice of most OECD countries, where doctors are salaried—and to allow them to act as the gatekeepers of Medicare. [31] The fact that doctors are the gatekeepers of the system has made it more difficult to establish primary health facilities in which doctors are no longer the gatekeepers but operate as part of a multi-disciplinary team of medical professions; such facilities rely more on alternatives to surgery to address patient problems. In Canada, patients come first to their doctor, who has the responsibility of ordering tests or referring patients to specialists. Thus, when Medicare was created decision-making with respect to wait times was decentralized and in the hands of doctors, hospitals, and regional health authorities. Studies of doctors’ behaviour with respect to waiting list management [32] found that managing waiting lists took time and money; the lists had to be updated, prioritized, and appointments rescheduled. Some doctors were

[30] Wait Time Alliance (2015), *Eliminating Code Gridlock in Canada’s Health Care System: 2015 Wait Time Alliance Report Card: 2*. In Ontario, there were 3,812 patients designated Alternate Level of Care (ALC) waiting in an acute or post-acute care bed as of May 31, 2015. As well, 41% of ALC patients in those beds were waiting for long-term care placement. In April 2015, 13.7% of the in-patient beds in the province were occupied by ALC patients. The rates ranged across the regions from a low of 6% to a high of 27%.

[31] It should be noted that fee-for-service payment and making doctors the gatekeepers of the health-care system were compromises reached to get their support for Medicare in Saskatchewan. While some individual doctors, especially family physicians, are willing to move to salaries and give up their gatekeeper role, no provincial medical association representing doctors has been willing to give up either across the board.

[32] Health Canada (1998), *Waiting Lists and Waiting Times*: 17.

diligent in fulfilling their responsibilities; others were not. The system could also be “gamed”; for instance, patients could be on more than one waiting list. There were as well reasons that doctors and regional health authorities would not see reducing waiting lists as a priority. Waiting lists represented a stock of available work. For both doctors and regional health authorities waiting lists helped them bargain for more resources from governments. If there was a backlog of patients waiting for treatment, then, there was a strong argument that more government funding was needed. [33]

Thus, the fact that Canada has longer waiting lists than other OECD countries is related to the way that Medicare was structured and funded. However, Canadian governments have historically shown an unwillingness to make any fundamental change in the funding and structure of Medicare; instead they have relied on other policy tools, such as improved management, incremental changes, and increased funding to reduce wait times.

[33] Health Canada (1998), *Waiting Lists and Waiting Times*: 13, 17.

Governments' Slow Response to Lengthy Wait Times

Despite mounting evidence of the adverse health effects of long waits for treatment, governments were slow to respond for a variety of reasons. Some groups downplayed the negative effects of wait times and even argued that they could in some cases be beneficial. Advocates of universal, publicly funded health-care systems argued that wait lists are a “far more equitable means of allocating scarce resources” than price rationing. [34] That is, waiting lists were preferable to implementing user fees or co-payments, common in Western European countries with shorter wait times. From a medical perspective, some policy experts argued that wait times could even prove to be beneficial since they allowed patients to reflect more on the implications of the proposed interventions and allowed for more conservative treatment options, such as watchful waiting. Also some contended that waiting lists showed that there was no excess capacity in the system. [35] Dissenting Justices in the *Chaoulli* case portrayed waiting lists as being unreliable since they often contained inadequate and outdated information. The idea that those on waiting lists were suffering, both mentally and physically, was also downplayed by the dissenting justices who argued that patients’ stress might also be related to a lack of information or anxiety about the procedure. [36]

The slow response was also related to the fact that it was patients who were most directly affected by wait times, while the health-care system was organized around the providers, whose interest in tackling wait times was uneven at best. It was the doctors, hospitals, administrators of regional health authorities, and departments and ministries of health who were responsible for collecting data about and managing wait times; thus, their views about waiting lists is crucial in understanding how the issue was handled. Especially revealing was the survey commissioned by Health Canada in 1998 in which various groups were asked their opinions on wait times and whether or not they were long and serious. Most, such as the providers and administrative and consumer groups, were unanimous in believing that wait times were excessive, growing and likely to continue. In striking contrast was the alternative view that there was “no evidence of adverse health outcomes from waiting lists in their

[34] Health Canada (1998), *Waiting Lists and Waiting Times*: 207.

[35] Health Canada (1998), *Waiting Lists and Waiting Times*: 3.

[36] *Chaoulli*, par. 219, par. 220.

jurisdictions, and that waiting did not inhibit access to medically necessary services”. This view that waiting lists were not really a problem was expressed by the health departments and ministries, the very people in charge of managing the system and gathering the data about wait times. [37]

As the waiting lists grew in the 1990s, the idea that the problem was primarily one of capacity—a lack of doctors and hospital beds—was popular, especially with doctors. The fact that cuts had been made to health budgets in the early and mid-1990s to balance budgets added fuel to this argument. From the perspective of doctors, if capacity was the problem then the solution was more funding rather than fundamental changes to the organization of the system. Governments like Saskatchewan also found the argument appealing; it was easier to provide more funding than it was to try to reorganize the system and face the potential opposition of powerful stakeholders like doctors. [38] A 1998 survey of administrators in hospitals and regional health authorities found that 81% believed that inadequate resources were important or very important determinants of waiting times.[39] Thus, administrators in the health-care system agreed with the doctors that the main cause of waiting lists was capacity and the primary solution was more money for the current system, rather than any fundamental changes to the structure and management of the system, which they administered and dominated.

Thus, patients suffered the consequences of long wait times, but those responsible for administering and managing the health system were either not convinced that the waits for treatment were a major medical problem or, if there were a problem, the consensus was that simply giving more money to the existing system was the solution. The 2002 Senate report on health care captured nicely the problem when it stated: a “major contributing factor to growing wait times has been the slowness of the ‘players’ in the system—hospitals and their specialist physicians and surgeons—to apply systematic management to waiting lists”. [40]

Patients were powerless since they lacked the data that would provide the evidence to back up their concerns about long waits for treatment. Doctors, hospitals, regional health authorities, and health departments were responsible for collecting data about wait times. The 1998 Health Canada study found the information to be limited, uneven, and variable. In a public system in which government agencies fund, develop policy, administer health, and provide

[37] Health Canada (1998), *Waiting Lists and Waiting Times*: 11, 7.

[38] Tom McIntosh, Michael Ducie, and Courtney England (2007), *Managing Wait Times in Saskatchewan*, unpublished manuscript (Institute of Intergovernmental Relations, Queen’s University): 25–27, <http://www.queensu.ca/iigr/sites/webpublish.queensu.ca/iigrwww/files/files/Res/crossprov/SK-Waiting_Lists.pdf>.

[39] Health Canada (1998), *Waiting Lists and Waiting Times*: 10.

[40] The Standing Senate Committee on Social Affairs, Science and Technology (2002), *The Health of Canadians: The Federal Role*, vol. 6: 116.

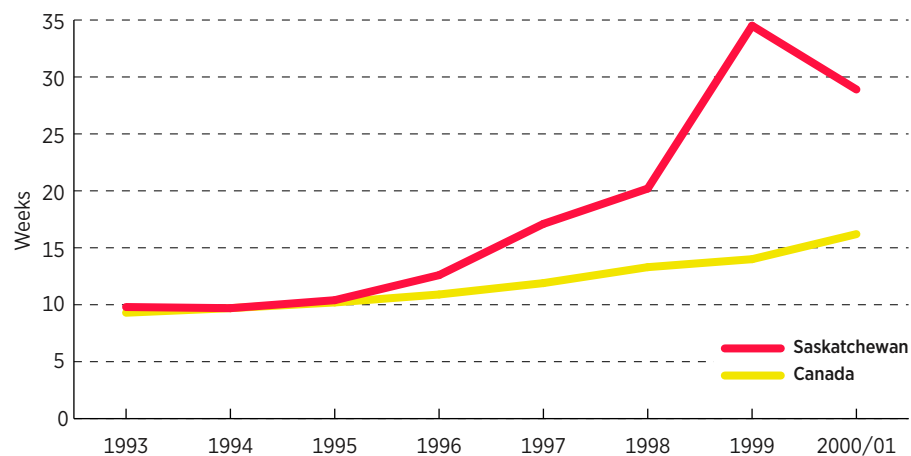
services, basic information that would be available in another setting, such as the costs of individual procedures, was not tabulated. Regarding wait times, the information kept by different hospitals and regions varied; there was no structured process to prioritize the urgency of those on the lists and no systematic assessment of the effect of wait times on patients. [41] If information is power, then the power over waiting lists rested in the hands of those who ran the health-care system and they showed no interest in ensuring that patients had accurate information about the waiting lists that were affecting their health. More transparency and accountability were required, but the evidence showed that neither would come from within the system.

[41] Health Canada (1998), *Waiting Lists and Waiting Times*: 64, 66, 70.

The Role of Think Tanks in Pressuring Governments to Act

In the 1990s as wait times increased—in 2001 wait times were 74.2% [42] higher than in 1993—information about waiting lists was provided to the public, not by governments but by research institutes (figure 1). In the early 1990s, the Fraser Institute launched Canada’s only comprehensive study of wait times across all specialties and provinces. [43] The primary source of information was surveys of specialists across Canada and the reports tracked the differences between what specialists thought were clinically reasonable wait times and actual wait times (measured from consultation to treatment). The reports also compared the total wait time between referral from a general practitioner to receipt of treatment in provinces and tracked the trajectory of wait times from year to year.

Figure 1: Median wait between referral by GP and treatment, Canada and Saskatchewan, 1993–2000/01



Source: *Waiting Your Turn: Hospital Waiting Lists in Canada* (various authors, various editions, 1993–2015). Fraser Institute.

[42] Michael Walker and Greg Wilson (2001), *Waiting Your Turn: Hospital Waiting Lists in Canada* (11th edition), Fraser Institute.

[43] Various authors (1990–2015), *Waiting Your Turn: Wait Times for Health Care in Canada*, <www.fraserinstitute.org>.

Government policy makers and academics initially dismissed the reports as being scientifically unsound since the wait times “are often generalized from few survey responses”. [44] It is true that specialists had a lower threshold for what they considered acceptable wait times than did those involved in setting benchmarks for provinces. However, when one considers the OECD’s emphasis on measuring the total duration of the patient’s journey from GP referral to treatment, the Fraser Institute’s approach, which tracked the wait time from GP referral to specialist and then specialist to treatment, is more thorough than the approach taken by provinces like Saskatchewan, which tracked the date on which the health region receives the booking form from the surgeon to surgery. [45] The latter approach would ignore the wait to see a specialist and delays for tests, scans, or imaging; also, the provincial lists often include urgent surgeries, which are fast tracked, while the Fraser Institute only tracked elective surgeries. While the merits of differing methodologies [46] can be disputed, what is indisputable is the trend line: wait times were increasing, they were much longer than specialists considered medically acceptable, and in some provinces patients waited much longer than in others. If information is power, then, patients waiting for treatment and those who were motivated to advocate on their behalf had the data to show that Canadian wait lists were too long, and were growing.

The Fraser Institute’s reports had a devastating impact on Saskatchewan. The province often had the longest waiting lists in Canada, and Saskatchewan patients were often waiting twice as long as in provinces like Ontario. To make matters worse, while government officials tried desperately to discredit the methodology of the Fraser Institute’s reports, the media accepted them as “gospel”. [47] Newspapers, radio, and television heralded the annual release of the Fraser Institute wait times data with headlines like “Saskatchewan longest total surgical wait time”, or “Saskatchewan wait times the country’s longest”. [48]

Bolstered by the data showing Saskatchewan wait times were long, growing, and well above what would be considered medically acceptable, patients stepped forward to tell their stories and demand action. One woman with a painful back problem had been on a waiting list for treatment for more than a year, when she was told that she would have to wait another six months. She reported that her health was deteriorating and she was on morphine and fearful

[44] McIntosh, Ducie, and England (2007), *Managing Wait Times*: 8.

[45] Siciliani, Borowitz, and Moran (2013), *Waiting Time Policies*: 42–43. It should be noted that the provincial website now includes wait times from consultations with specialists.

[46] For a comparison of methodologies used to measure wait times, see Nadeem Esmail (2013), *Measuring How Long Canadians Wait for Health Care*, in Steven Gliberman, ed., *Reducing Wait Times for Health Care: What Canada Can Learn from Theory and International Experience* (Fraser Institute): 15–43.

[47] McIntosh, Ducie, and England (2007), *Managing Wait Times*: 8.

[48] *Saskatoon Star Phoenix*, October 8, 2001; *Regina Leader Post*, October 16, 2007.

of becoming addicted to it. Her challenge to the government was uncompromising: “I would like to know what is being done about hospital wait times.” [49] The issue of wait times also dominated sessions of the legislature in the early years of the 21st century. There were petitions pleading for “timely access to medical treatment”, reports of patients leaving the province and paying for their own treatment and many tragic stories of human suffering. An 81-year-old man introduced in the legislature by an opposition Member had blocked tear ducts that meant that he could not see. He needed sight restoration surgery, but had been told the wait time was two years on top of the 18 months that he had already waited to see an ophthalmologist and get x-rays. [50]

The combination of the data about long and growing wait times, the moving stories of patients waiting in line and the Supreme Court’s decision led to a fundamental change: a health system that had been dominated by stakeholders and interest groups was being forced to take account of aggrieved patients and pay attention to their needs.

The impact of the Fraser Institute’s annual reports on wait times on the Saskatchewan government’s decision making has been documented in an unpublished survey of civil servants, physicians, academics, regional health authority employees, elected officials and representatives of stakeholder organizations. Part of the study considered why the Saskatchewan government became so focused on wait times. The main conclusion of the survey was that the Fraser Institute reports on wait times were “extremely influential” in driving the issue of wait times and the length of waiting lists onto the political agenda. The annual reports were also a “lightening rod for political action on the part of organized interests within the health care system”. The reports kept the issue of wait times in the public eye and helped feed the idea of a health system that was deteriorating and in crisis.[51] The fact that Saskatchewan appeared to have among the longest wait times in Canada meant that by the late 1990s the wait list issue had become “as politically threatening to the NDP government as hospital closures in the early 1990s.” [52] The depth of the problem for the government was striking: not only did it not have a strategy to tackle long wait times, it did not even have reliable data to provide to the public to counter the Fraser Institute’s information.

[49] Surgery Wait Frustrates Sask. Woman, *Saskatoon Star Phoenix*, September 18, 2007.

[50] Government of Saskatchewan (2007), *Hansard* (May 1): 1444; “Mr. McMorris” (March 29): 1092.

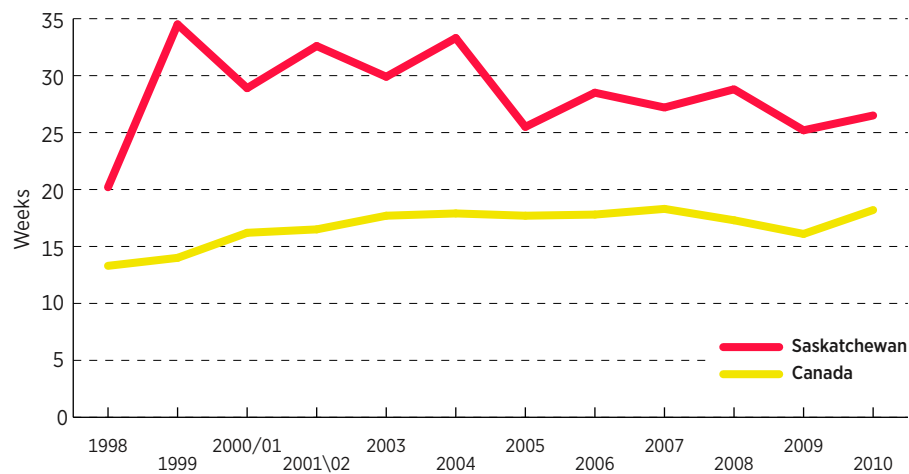
[51] McIntosh, Ducie, and England (2007), *Managing Wait Times*: 25, 8–9.

[52] Tom McIntosh, and Gregory P. Marchildon (2009), *The Fyke in the Road: Health Reform in Saskatchewan from Romanow to Calvert and Beyond*, in Howard Leeson, ed., *Saskatchewan Politics: Crowding the Centre* (University of Regina Press): 348.

Government Action on Wait Times

As public pressure mounted, the Saskatchewan government was forced to act, and 1998/1999 marked a significant turning point (figure 2). In 1998, the government commissioned the Task Team on Surgical Waiting Lists to tackle the issue and soon after the Saskatchewan government put more money into health care to address waiting lists. Though the money was quickly gone, the waiting lists remained, a reality that should not have been surprising in light of the major study released the year before by Health Canada. One of its conclusions was: “Adding resources without fundamentally improving management, audit, and evaluation is not only a futile strategy for dealing with waiting lists: it may also create serious opportunity costs elsewhere in the health care system”. [53] The failure of the 1999 funding experiment discredited the main solution to wait times supported by doctors and administrators of hospitals and regional health authorities. While more funding to increase capacity could be part of the solution to reducing waiting lists, it would not by itself address the problem. Broader, more systemic solutions were required, which meant that the leadership on wait times was left to senior public servants.

Figure 2: Median wait between referral by GP and treatment, Canada and Saskatchewan, 1998–2010



Source: *Waiting Your Turn: Hospital Waiting Lists in Canada* (various authors, various editions, 1993–2015). Fraser Institute.

[53] Health Canada (1998), *Waiting Lists and Waiting Times*: 13.

By the beginning of the twenty-first century, there was a core of public servants in Saskatchewan whose experience and research convinced them that lengthy waiting lists were the result of a systematic problem that would require major changes in how the health-care system was managed and operated. [54] The champions of systemic change within the bureaucracy became a driving force in looking beyond Saskatchewan's borders for solutions and they helped spearhead the major changes that laid the foundations for the SSI in 2010.

All provinces were challenged by lengthy wait-times and provincial governments collaborated and learned from each other as they struggled, often through trial and error, to address the issue. In 1999, Saskatchewan joined the Western Canada Waiting List Project and worked collaboratively with other provinces, health authorities, and stakeholder groups to find better ways of managing waiting lists, a process that involved surveying what was occurring in Canada and internationally. Saskatchewan's officials specifically focused on the United Kingdom and its successful initiatives to reduce wait times. Saskatchewan also learned a great deal from the Ontario Cardiac Care Network, which established a centralized registry of patients and a standard urgency rating system that prioritized patients for treatment. [55] Provincial representatives also attended interprovincial conferences, such as Taming of the Queue (2005), a symposium on wait-list management, at which the co-Chair David Naylor drew a direct link between work done in Ontario on the Cardiac Care Network and subsequent Saskatchewan initiatives on wait time reduction. [56] As well, the sharing of knowledge among the provinces occurred as health policy professionals moved across the country; for example, Peter Glynn, who had worked for Health and Welfare Canada and had also been President and CEO of the Kingston General Hospital, led the Saskatchewan Surgical Care Network (SSCN).

When it was established in 2004 to reduce wait times, the SSCN was heralded by Senator Michael Kirby, author of the 2002 Senate study of health care, as "the country's first comprehensive system to rate and track all patients waiting for surgery". [57] Some of its main ingredients, such as standardized criteria for assessing and prioritizing patients, targeted times for treatment, and the use of websites to publicize wait times, laid the foundations for the SSI (see [Appendix](#), p. 35).

[54] McIntosh, Ducie, and England (2007), *Managing Wait Times*: 28.

[55] B. Monaghan, C. Morgan, and B. Shragge (2001), *Through the Looking Glass: The Cardiac Care Network of Ontario Ten Years Later*, *Health Care Quarterly* 4, 43: 30–37.

[56] McIntosh, Ducie, and England (2007), *Managing Wait Times*: 22.

[57] Michael J.L. Kirby and Wilbert Keon (2004), *Why Competition Is Essential in the Delivery of Publicly Funded Health Care Services*, *IRPP Policy Matters* 5, 8: 30.

The final push to establish the SSI came with the *Patient First* report, commissioned in 2007 by the newly elected government of Premier Brad Wall. The 2009 final report noted that “[a]ddressing surgical and diagnostic wait lists is of critical importance” and it “urge[d] the Province to examine all options to address this top-of-mind patient concern”. [58]

In 2010, the SSI was unveiled by the government. What is most surprising about the SSI is that many of its components were not new but had been advocated or implemented earlier or elsewhere (see [Appendix A](#), p. 35). What was most innovative was the way the ideas were communicated and the public profile and leadership that drove the initiative.

The 2015 Report of the Advisory Panel on Healthcare Innovation written for Health Canada analyzed what drives innovation in high performing global health-care systems. The report found that three of the main factors driving change are: leadership in defining “the vision and direction for change”, the engagement of front-line staff in embracing change, and a patient-centered focus, “a responsive system that is designed around their needs, not around the needs of providers and system managers”. [59] The SSI provides a case study of how the ingredients for innovation—leadership, front-line staff engagement, and patient focus—were combined with an emphasis on accountability to dramatically reduce wait times for elective surgery. In essence, what was achieved was a change in the culture as to how those in the health-care system managed waiting lists and treated patients.

Wait time targets and guarantees

The guiding principle of the SSI was the bold and very specific commitment that by March 2014 no patient would wait more than three months for surgery. Was this commitment a target or a guarantee? Targets are aspirational goals without significant consequences if they are not met. Targets were part of the 2004 Health Accord in which provinces agreed to establish “evidence-based benchmarks for medically acceptable wait times” and agreed on common definitions for wait-time measurement. [60] Also, other provinces had established targets; for example, in 2009 British Columbia required that 90% of patients be treated within the national waiting time benchmarks. [61]

[58] Dagnone (2009), *For Patients’ Sake*: 27.

[59] Advisory Panel on Healthcare Innovation (2015), *Unleashing Innovation*: 36–37.

[60] Canadian Institute for Health Information [CIHI] (2012), *Health Care in Canada: A Focus on Wait Times*: 3.

[61] Siciliani, Borowitz, and Moran (2013), *Waiting Time Policies*: 109.

Guarantees, on the other hand, involve repercussions if the targets are not met and can be effective in reducing wait times. A 2013 OECD study on reducing wait times concluded that “[w]ait time guarantees have become the most common and effective policy tool to tackle long waiting times, but are only effective if enforced”. [62] An example cited was the United Kingdom, whose health-care system was studied by officials in Saskatchewan Health, where the “main contributory factor” in reducing wait times was the “use of clear targets for providers over an extended period of time with obvious and serious sanctions if those targets were breached”. [63] In Canada, the proposal in the 2002 Senate Report on health care that governments should be required to establish benchmarks for wait times and to pay for patients to receive care in other jurisdictions if the benchmarks were exceeded fits the definition of a guarantee, but the recommendation was never implemented. [64]

Were there repercussions if the Saskatchewan government did not live up to its commitment to dramatically reduce wait times? What was most striking about the Saskatchewan wait-time target was that it was so specific and easy to understand. It did not require sifting through wait-time data for patients and the public to know whether or not patients were receiving their surgery within three months and the target date for the goal to be achieved was very specific: March 2014. Also, the regular reports of research institutes like the Fraser Institute meant that the public would be provided with regular, third-party information about whether or not the goals were being met.

The targets established in 2010 to reduce wait times were similar to the targets established in the 1993 Saskatchewan budget, when I was Finance Minister, to reduce the deficit and balance the budget in 1996. To the outside world the commitments may seem to be just targets. However, in both cases, the government was putting its credibility on the line. Public servants knew that meeting the targets was a major priority of the government. Government members knew that failure to meet, or come close to meeting, the targets on such a high-profile commitment would be a significant problem for government members in seeking re-election. At stake were their jobs and the power that comes with being the government rather than the opposition.

Thus, the goal of reducing wait times was more like a guarantee than a target; it reflected the commitment of the government and symbolized the leadership, vision, and direction for change that drove the Saskatchewan Surgical Initiative.

[62] Siciliani, Borowitz, and Moran (2013), *Waiting Time Policies*: 11.

[63] Peter C. Smith and Matt Sutton 2013, United Kingdom. In Siciliani, Borowitz, and Moran (2013), *Waiting Time Policies*: 310.

[64] The Standing Senate Committee on Social Affairs, Science and Technology (2002), *The Health of Canadians: The Federal Role*: ch. 5.

Centralized registry and standards for patient prioritization

Another part of the SSI involved taking the management of waiting lists from the control of doctors, hospitals, and regional health authorities. Instead, a centralized surgical registry was created that included all patients waiting for surgery across the province. As well, province-wide standards for assessing and prioritizing those on waiting lists were created so that patients could be treated according to the severity of their condition. Centralizing waiting lists and requiring prioritization based on established standards along with pooling referrals (mentioned below) meant that waiting lists could be managed more efficiently and available resources used more effectively. Again, the 2013 OECD study showed that improving “clinical prioritization [sic] for elective treatments” could be an effective tool in reducing wait times. [65] The creation of a province-wide centralized registry and standard measures for prioritizing those on the lists when combined with benchmarks for timely care were common ingredients in the SSCN and in the efforts of other provinces to reduce wait times. Changing the management of waiting lists affected the power of doctors to control the lists; yet it was achieved with no public opposition from doctors or other stakeholders.

Collaborative decision-making, integration and coordination

A critical element of the SSI was the fundamental change in the culture and decision-making process in healthcare. The *Patient First* report, like that in 2015 from Health Canada, painted a picture of a health-care system whose fundamentals had changed little since the 1960s. It was plagued by poor communications among key players within the system such as providers and management, or government departments more interested in protecting their turf than helping patients. The system lacked integration and coordination. The picture was of a “fractured mode of operation”, where “[c]are is delivered in silos”, that fail to treat patients as “whole people rather than parts that need fixing”. The health system was difficult for patients to “navigate” and Dagnone concluded it was not really “functioning as a ‘system’”. [66]

The lack of coordination, collaboration, and integration had to be addressed and one part of the solution was a more collaborative decision-making model, which involved all employees, including clinical and support staff, in decision-making and an emphasis on teams working together toward common

[65] Siciliani, Borowitz, and Moran (2013), *Waiting Time Policies*: 12.

[66] Dagnone (2009), *For Patients’ Sake*: 53, 6–7, 45.

goals. [67] The fundamental culture change that was at the heart of the SSI was described in one presentation as “thinking and acting as one”, which involved shared ownership across regions and with providers, health-care organizations, staff, and patients who worked in groups to chart the changes necessary to reduce wait times and ease the patient’s journey through a complex health care system. [68] Study groups, ranging in size from 30 to 90 people, were created and included civil servants, regional health authority personnel, doctors, nurses, health-care workers, and patients. The groups began with the overarching goal of reducing surgical wait times and then charted the vision specific to their area, and worked together to develop actions to implement the vision.

Patient First

Another key element of the cultural change in the SSI was its patient-first philosophy. A major problem with the health-care system, according to Dagnone, was that the interests of stakeholders—doctors and other health-care professionals, unions, management, and government departments—dominated it at the expense of the patients. For instance, the heavily unionized labour relations model was described as “an obsolete, adversarial, industrial relations approach that currently exiles patients from the process as employers and employees bargain from positions of strict self-interest”. As for the providers, Dagnone believed that “new care models are resisted by providers guarding their own interests to the detriment of patients”. More generally, he predicted that “[a]ny prescription for bold change will be met by resistance from interested parties”. [69]

The most fundamental cultural change that had to occur was to focus the system on the patients; as Dagnone put it “*Patient First* [would] be embedded as a core value in health care”. He explained that in a modern health-care system “the physician’s role needs to shift to include helping patients to self-manage and participate in their care”. [70] Patients were seen as the customers who should be listened to, taken seriously, and involved in their own care decisions.

Focusing on patients also helped to break down silos and integrate and coordinate services more effectively. Providers worked together as teams to develop patient pathways that mapped out the process of a patient’s treatment from diagnosis to recovery. Multidisciplinary public clinics were also created to treat specific ailments, such as hip and knee problems. [71]

[67] Dagnone (2009), *For Patients’ Sake*: 25.

[68] Saskatchewan Ministry of Health (2010), *Sooner, Safer, Smarter: A Plan to Transform the Surgical Patient Experience* (March), <www.sasksurgery.ca/pdf/sksi-planstotransform.pdf>.

[69] Dagnone (2009), *For Patients’ Sake*: 15, 14, 6–7, iii.

[70] Dagnone (2009), *For Patients’ Sake*: 6, 40.

[71] Mark Wyatt, Saskatchewan Surgical Initiative/Accreditation Canada, <<http://accreditation.ca/saskatchewan-surgical-initiative>>.

The patient focus was also apparent in the involvement of patients in the planning and decision-making bodies, where the focus was on “shared decision-making”—better communications between doctors and patients and more patient involvement in decisions about treatment and care. The Health Quality Council also worked with the health regions to develop a monthly survey that provided feedback from patients. [72]

Several initiatives focused on making the system more transparent for patients, empowering them to make choices, and helping them navigate the complex world of the Canadian Medicare system. Waiting lists were integrated and centralized but also made readily available to patients through an easily navigable web-based system that allowed patients to see their status on the waiting list and how long their wait might be. Many doctors agreed to have their referrals pooled so that, rather than being limited to the specific specialist to whom a patient had been referred, a patient could use the internet to find the list of specialists and the length of wait times to see them. Patients retained the right to choose their specialist, but did so with the knowledge of the length of the wait involved. The pathways mentioned above also helped streamline the process for patients and ease their transition from diagnosis to treatment to recovery. Short communiques available in print and on the web helped explain to patients how to navigate the system and seek help if needed. The patient-centered focus meant that patients were given the opportunity to play their part in reducing their wait time for treatment.

Accountability

Accountability was also a major component of the SSI. There were regular updates on the goal of reducing surgical wait times to three months; there were performance targets and system-wide targets. Some of the performance targets, such as the percentage of acute-care beds being occupied by patients waiting for placement in long-term care, sought to address some of the factors that produced long wait times for surgery. Others, such as indicators of patient satisfaction, reinforced the patient-oriented focus of the SSI. The system-wide targets built into regional health authority pay for performance reflected the enhanced accountability expected of managers to play their part in making the SSI a success. [73]

[72] Saskatchewan Ministry of Health (2010), *Sooner, Safer, Smarter*: 8, 14, 15.

[73] Taming of the Queue, 2013. <http://www.cfhi-fcass.ca/NewsAndEvents/Events/Taming_of_the_Queue/TamingQueue2013.aspx>

Communications

One of the reasons that the SSI was successful was the priority placed on communication with the public. Symbolic of this was the choice of the person who spearheaded the SSI. Mark Wyatt was not a doctor or a career public servant but a former journalist who had covered the Legislature in the 1990s and had first-hand experience with the public-relations problems with wait times. The communications were clear, crisp, and written in plain language. The web sites were user friendly and easy to navigate. The Wait Time Alliance performs an annual assessment of provincial wait-time websites that includes five criteria: timeliness, comprehensiveness, patient friendliness and accessibility, performance, and quality or reliability. The process also involves input from patient groups who provided feedback on their use of the sites. [74] Saskatchewan was given an A for its website in 2015.

The communications also helped reinforce the idea that the SSI was patient focused. Its tag line was “Sooner, Safer, Smarter”, which meant that as well as reducing wait times, the goals were to improve safety—for instance, new standards and protocols were developed to prevent hospital-based infections—and promote innovation. The holistic approach helped to reassure patients and the public that wait times were not being reduced at the expense of quality or safety. Moreover, changes made were explained in the context of the ways that patients benefitted rather than mentioning how the providers or the public treasury benefitted. The use of private clinics to deliver services not only increased capacity, they also saved the government money, a fact that was not profiled in the communications. The government sold the idea that the SSI was not about saving money for the government or making the system better for the providers; rather it was about the patients, their wait times and their safety.

Selling the SSI to the public was one thing, but persuading the providers of its merits or at least neutralizing them was another issue. Governments have good reason to fear doctors, nurses, and other health-care professionals: their opposition to changes made in health care by governments can be very problematic in that, if they criticize health policy changes and warn that they will not be good for patients, then the patients and the public tend to believe the health professionals rather than the politicians. Wyatt, from his experience as a journalist, would have witnessed the health reform undertaken in the 1990s by the government of Premier Roy Romanow (in which I was a cabinet minister) and would have known the pivotal role played by the stakeholders. The Saskatchewan Medical Association (SMA), the Saskatchewan Union of Nurses (SUN), and the public-sector unions were initially publicly supportive

[74] Wait Time Alliance (2015), *Eliminating Code Gridlock in Canada’s Health Care System: 2015 Wait Time Alliance Report Card*: 5.

of the health-care reforms of the 1990s. However, when difficult measures were adopted that adversely affected their members, the providers' support waned, their public comments became more critical, and public support for health reform dropped dramatically. This dynamic was the most important reason that the Romanow government abandoned its commitment to health-care reform.

In contrast to the 1990s, stakeholders' criticisms were neutralized by various aspects of the SSI. One was the communications plan. Rather than relying on support from the SMA or SUN, as was the case in the 1990s, the government went over the heads of the stakeholders to persuade patients and the public that the SSI was about trying to reduce wait times for long-suffering patients. In a health-care system renowned for catering to the providers, it was a transformative and welcome message, that was backed up by some of the substantive changes made to the way that wait times were managed.

Moreover, the collaborative decision-making process was important in deflecting criticism. In the 1990s, the government sought and initially got the support of the unions or associations representing the providers: the SMA, SUN and other health care unions. However, when some of the reforms adversely affected their members, these organizations acted to represent and protect the interests of their members, which necessitated becoming increasingly critical of the government's reforms. In contrast, under SSI, the planning and decision-making groups included doctors, nurses, health-care workers, and others, not as representatives of the SMA, SUN, or the unions but in their capacity as professionals. As well, doctors, nurses, and other health-care professionals involved in the group decisions became champions for the reforms who helped to persuade others in their profession of the merits of the SSI.

A final consideration was that, while patients suffered most directly from long wait times, doctors, nurses, and others in the system would have been aware of their negative effects on patients. In the case of doctors and administrators of hospitals and regional health authorities, their main solution—increasing the capacity of the existing system—had been discredited by the late 1990s and with no other alternative to offer it was difficult to criticize the SSI that was rolled out so effectively by the government.

Increasing Capacity and the Role of Private Clinics

While increasing capacity by itself was not a solution to reducing wait times, successful wait-time reduction involves increasing capacity. For example, in the United Kingdom, along with targets for wait times and timely monitoring and reporting, additional resources were added to enhance capacity. [75] Other studies have linked reduced waiting lists to increased capacity. [76] In 2010, the government stated that surgical volumes would have to be increased by 8% over four years. Some of the increased capacity was achieved by better use of regional hospitals and longer hours for surgery. [77] Between 2010 and 2014, \$176 million was invested in surgical services, with another \$60.5 million being spent in 2014/15. Some of the money was spent on increasing the human resources capacity of the system. The number of operating nurses was increased by doubling the number of core funded seats for training nurses. Doctors worked overtime, including performing surgeries on Sundays. And, there was more funding for hospitals, home care, and post-operative support and rehabilitation. [78]

Capacity was also increased by the introduction of private, for-profit clinics within the publicly funded health-care system, the most controversial aspect of the SSI. The ground had been laid for the clinics in the *Patient First* review which recommended “identifying those services that can be provided outside of expensive hospital settings in alternate sites”. [79] The government stressed that the clinics were being introduced to increase the surgeries performed and thereby reduce wait times and to free up hospital beds for those with more acute health-care problems.

The use of private clinics to deliver health-care services is common in other OECD countries and there are many reasons that procedures like elective day surgeries can be delivered more effectively in clinics. Hospitals are expensive—it has been estimated that maintaining a bed in a hospital for a day costs

[75] Siciliani, Borowitz, and Moran (2013), *Waiting Time Policies*: 310.

[76] Stephen Martin and Peter. C. Smith (1999), Rationing by Waiting Lists: An Empirical Investigation, *Journal of Public Economics* 71:141–164. Jeremy Hurst and Luigi Siciliani (2003), *Explaining Waiting Time Variations for Elective Surgery across OECD countries*, OECD Health Working Papers.

[77] Saskatchewan Ministry of Health (2010), *Sooner, Safer, Smarter*: 10.

[78] Duncan (2014), *Saskatchewan Surgical Initiative*.

[79] Dagnone (2009), *For Patients' Sake*: 28.

about \$842 [80] —and they are dominated by health-care unions and associations whose contracts impose constraints on the capacity to manage hospitals efficiently and to innovate. Clinics are located outside the complex and expensive hospital settings and have the advantage of only performing specific procedures that can be delivered more effectively and efficiently. Also, they are less susceptible to hospital-based infections and offer more convenient access. [81] Thus, in another OECD country the Saskatchewan government’s decision to allow 34 day-surgery procedures, such as cataract, knee, shoulder, dental, ear, nose, throat, and orthopedic surgery, to be performed in private clinics would have attracted little public attention.

In Saskatchewan, however, the use of private clinics generated significant opposition. Health-care unions opposed the policy as did the Saskatchewan Health Coalition, a group committed to having Medicare-covered services delivered by public-sector employees working in publicly owned facilities. Shortly after the government announced its intention to establish private clinics, the Health Coalition publicly attacked the plan. The clinics were depicted as the beginning of the privatization of Canadian health care and were considered to be contrary to the Canada Health Act. The group also warned the public that the clinics would drain staff from the public system, which would lead to shortages of nurses and other health-care professionals and longer wait times. They also alleged that the clinics would be more expensive since the companies had to make a profit and the “fast profits will soon drain precious funding from the public health care system and further cripple it”. Another warning was that the clinics would “cherry pick” the healthiest patients leaving the public system to cover the costs of those with more complicated conditions. [82] A group of doctors, calling themselves Canadian Doctors for Medicare warned that the “centres must be watched closely to ensure that they’re not favouring patients with more straightforward cases” and that they did not “poach health care workers from the public system”. [83] Thus, the opponents of the clinics tried to persuade the public that the private clinics would threaten the fundamental principles and values of Medicare.

[80] Canadian Life and Health Insurance Association Inc [CLHIA] (2012), *CLHIA Report on Long-Term Care Policy: Improving the Accessibility, Quality and Sustainability of Long-term Care in Canada*: 4.

[81] Janice MacKinnon (2013), *Health Care Reform from the Cradle of Medicare*, Macdonald-Laurier Institute (January): 8.

[82] Saskatchewan Health Coalition Raises Concerns about Private for-Profit Surgery Clinics, *Saskatoon Star Phoenix* (September 12, 2012); The Sk Govt’s Millions of Dollars More for Privatization of Healthcare Is Flawed Policy, *Saskatoon Star Phoenix* (February 17, 2012).

[83] City’s Second Private Surgical Centre Opens, *Saskatoon Star Phoenix* (February 18, 2012).

The sustained criticism of the plan to use private clinics meant that it was essential that the Saskatchewan government be diligent in establishing a process for choosing the companies that would run the clinics and defining principles upon which the clinics would operate that were beyond reproach. Also, it is true that whether or not private, for-profit clinics deliver services effectively and efficiently depends on how diligent the government is in handling the process for choosing the companies and negotiating the contracts with them. In 2010, the principles upon which the private clinics would be created were published by Saskatchewan Health:

- third-party delivery must support a patient-first approach to health care through improving access, quality, and choice for patients and their families;
- third-party delivery must fully comply with the principles and guidelines of the Canada Health Act, and all relevant provincial legislation and regulations;
- third-party delivery must be fully integrated within the publicly funded, publicly administered health system;
- third-party delivery must meet all necessary health system safety and quality standards;
- third-party delivery must be implemented through an open, consistent, equitable, and fully transparent selection process;
- 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. [84]

Meeting the last criterion was problematic since there was no existing mechanism to determine the costs of various publicly funded procedures. Consequently, a working group was created and it recommended “procedural activity-based costing”, which is complicated but provides costing on the basis of procedures and has an established track record in Ontario and Alberta. [85]

The criteria contained in the requests for proposals were also made public. Companies were evaluated on the basis of credentials and experience,

[84] Saskatchewan Ministry of Health (2010), *Third Party Delivery Costing Framework: Third-Party Delivery of Outpatient Surgery* (July): 3.

[85] Saskatchewan Ministry of Health (2010), *Third Party Delivery Costing Framework*: 4.

service factors, implementation schedules, and pricing. [86] In Saskatoon, the contract was awarded to Surgical Centres Inc., a Calgary-based company with more than 20 years of experience performing day surgeries in non-hospital settings in Alberta and British Columbia. The chosen companies then signed contracts with the health regions specifying the number of procedures to be performed, the time frame, and the costs. The facilities were accredited by the Saskatchewan College of Physicians and Surgeons and had to meet the same standards as hospitals.

The transparency about the process for selecting the companies and the criteria for their operation addressed the main arguments made by the clinics' opponents. Since patients would not be allowed to pay directly for the services, there was no queue jumping. There were no violations of the Canada Health Act: for example, the Act provided only that Medicare services had to be publicly administered and there was no requirement that they be delivered by public-sector employees in publicly owned facilities. "Cherry picking" of patients by the clinics was foreclosed since officials of the Regional Health Authority (RHA) determined which patients would be referred to the clinics. Regarding the concern about the clinics luring health-care professionals from the public sector, the companies were required to provide a human resources plan; for instance the Regina health authority and the clinic agreed not to compete for staff. In fact, the Regina private clinic was staffed by 20 registered nurses and licensed practical nurses who had retired but were attracted to the clinics because of the working hours, which were Monday to Friday with no on-call, shift, or week-end work. [87] The clinics were also good at publicizing what the facilities had to offer: bright and cheery settings, children's play areas, and easily accessible, free parking. [88]

What was not profiled by the government was the cost saving that the clinics brought to the government. In 2012, Saskatchewan Health compared the cost of performing the 34 procedures in private clinics and in hospitals. The results showed that in all cases the clinics were less expensive, in some cases, half the cost. Overall, the total cost of performing the 34 procedures in the clinics was 26% less than the cost would have been had the procedures been performed in the hospital (see tables 1, 2). [89]

[86] Regina Qu'Appelle Health Region News Release, (June 15, 2011).

[87] Operations Underway at the Regina Surgical Centre, *Regina Leader Post* (March 30, 2012); Saskatoon Health Region Selects Surgical Centres, Inc, *Saskatoon Star Phoenix* (June 15, 2011).

[88] Operations Underway at the Regina Surgical Centre, *Regina Leader Post* (March 30, 2012); Saskatoon Health Region Selects Surgical Centres, Inc, *Saskatoon Star Phoenix* (June 15, 2011).

[89] Saskatchewan Health (2012), *Saskatchewan Surgical Initiative Data*.

Table 1: Comparison of costs per procedure at Regina Qu'Appelle RHA (public), Aspen Medical Surgery Inc. (private) and Surgical Centres Inc. (private), 2012

Procedure	Regina Qu'Appelle	Aspen Medical Surgery Inc.
Shoulder Arthroscopy	\$2,957	\$2,300
Shoulder Arthroscopy & Bankhart's Repair	\$2,645 plus hardware	\$2,300 plus hardware
Shoulder Arthroscopy & Rotator Cuff Repair	\$3,032 plus hardware	\$2,700 plus hardware
Knee Arthroscopy	\$1,875	\$1,310
Arthroscopy, Anterior Cruciate Ligament (ACL) repair	\$3,706 plus hardware	\$3,200 plus hardware

Note: Implants will be billed at cost

Procedure—expanded services include:	Regina Qu'Appelle RHA	Surgical Centres Inc.
Cataract	\$1,273	\$617.50
Abdominoplasty	\$2,632	\$2,270
Breast Reductions	\$2,377	\$2,300
Rhinoplasty	\$1,755	\$1,670
Gynecomastia	\$1,845	\$1,760
Excision Axilla Sweat Gland	\$1,637	\$890
Bunionectomy	\$1,500	\$1,400
Tonsillectomy	\$1,313	\$1,255
Tonsillectomy & Adenoidectomy	\$1,334	\$1,255
Tympanoplasty	\$2,410	\$1,000
Tympanmastoidectomy	\$3,251	\$1,000

Note: Any implanted hardware cost is the same regardless of the delivery site (i.e., it is the same as Regina Qu'Appelle Health Region's cost).

Table 2: Comparison of costs per procedure at Regina Qu'Appelle RHA (public), Aspen Medical Surgery Inc. (private) and Surgical Centres Inc. (private), 2011

Procedure	Regina Qu'Appelle	Surgical Centres Inc.
Myringotomy & intubation	\$648	\$230
Septorhinoplasty	\$1,803	\$1,350
Nasal Septal Reconstruction/ Septoplasty	\$1,647	\$1,600
Endoscopic Sinus Surgery	\$2,552	\$2,000
Transobturator taping & Cystoscopy	\$2,011	\$1,200
Pediatric Dental	\$1,058	\$960
Shoulder Arthroscopy-Decompression	\$3,093	\$1,700
Arthroscopy & Bankhart's Repair	\$3,031 plus hardware	\$2,000 plus hardware
Knee Arthroscopy	\$1,706	\$1,200
Arthroscopy, Anterior Cruciate Ligament (ACL) repair	\$4,487 plus hardware	\$2,500 plus hardware
Bi-lateral Knee Arthroscopy	\$2,157	\$1,920

Note: Implants will be billed at cost

Procedure	Saskatoon RHA	Surgical Centres Inc.
Pediatric Dental	\$1,340	\$960
Cataract	\$593 plus custom packs and intraocular lenses	\$387.50 plus custom packs and intraocular lenses
Knee Arthroscopy	\$1,300	\$1,200
Anterior Cruciate Ligament (ACL) repair	\$3,212 plus hardware	\$2,500 plus hardware
Shoulder Arthroscopy-Decompression	\$2,526	\$2,000
Bankhart's Repair	\$2,486 plus hardware	\$2,000 plus hardware
Rotator Cuff Repairs	\$2,618 plus hardware	\$2,000 plus hardware

Note: The implanted hardware cost is the same regardless of the delivery site (i.e., it is the same as Saskatoon Health Region's cost).

The success of the private clinics

The “consistently high patient satisfaction ratings” for the clinics were cited by the government as evidence that they had been “embraced by patients”. [90] Selling private, for-profit health-care clinics in the birthplace of Medicare was no mean feat. What explains the success? The process for selecting and the criteria for operating the clinics were thorough and transparent, the obvious objections were anticipated and avoided—no queue jumping, no cherry picking of patients, no violations of the Canada Health Act—and the communications by the government and the clinics were very good. However, in linking private, for-profit clinics with a reduction in wait times the government struck a nerve with the public and patients. For some time, wait times had been the major health-care concern of citizens and, if private clinics could help to reduce wait times, then, people were willing to set aside their ideology, ignore the warnings of health interest groups, and give the clinics a chance.

The issue of the private clinics and the public’s reaction to them surfaced during a heated exchange in the legislature between Premier Brad Wall and the Leader of the Opposition, Cam Broten, in October 2015. The Opposition Leader was grilling the Premier on what appeared to be growing wait times for treatment when the Premier turned the debate to the issue of the private, for-profit clinics. He challenged the Opposition Leader to tell voters whether he would promise in the upcoming April 2016 election to close the clinics. The government, it seems, had done polling that showed that, after being operational for a few years, the clinics had won the support of Saskatchewan voters. More generally, polling also seemed to show that “voters are no longer measuring health care on philosophical rhetoric but [on] results.” [91]

March 31, 2014 saw the formal end of the SSI. The ongoing strategic leadership and advisory tasks were passed on to a newly established Provincial Surgical Oversight Team, which comprised patients, health providers, and health region and ministry representatives, whose task was to monitor results and “ensure that continuous improvement remains entrenched in surgical services”. Not all Health Districts succeeded in meeting the three-month target for surgeries, a shortcoming that the Health Minister acknowledged. Nonetheless, the progress was remarkable. On March 2014 there were 3,824 patients waiting longer than three months for surgery, 75% fewer than the 15,352 patients waiting that long in 2010. [92]

The dramatic improvement in wait times for elective surgery in Saskatchewan was substantiated by independent sources. In April 2015, a

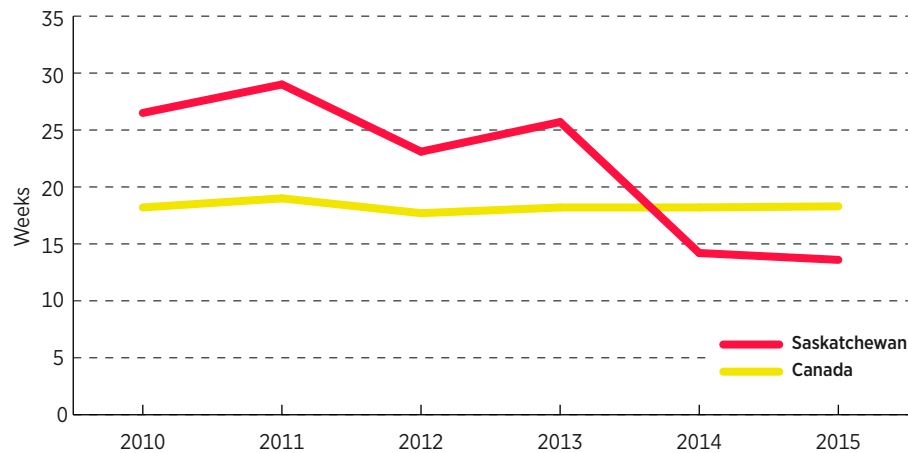
[90] Duncan (2014), *Saskatchewan Surgical Initiative*.

[91] Murray Mandryk (2015, October 28), Sask. Premier Brad Wall Winning the Wait-Times War, *Regina Leader Post*, <<http://www.leaderpost.com/business/mandryk+saskatchewan+premier+brad+wall+winning+wait+times/11476666/story.html>>.

[92] Duncan (2014), *Saskatchewan Surgical Initiative*.

report by the Canadian Institute for Health Information showed a dramatic increase in the number of hip, knee, and cataract surgeries being performed in Saskatchewan within established benchmarks. [93] Especially noteworthy is the data from the Fraser Institute’s *Waiting Your Turn* annual report. In the 2010 report, the procedure-weighted median wait time across 12 specialties for Saskatchewan surgical patients from GP referral to treatment was 26.5 weeks, the longest waits outside of Atlantic Canada, and more than 12 weeks longer than Ontario whose patients had the shortest median waits at only 14 weeks. [94] In the 2014 report, the wait time for Saskatchewan patients from GP referral to treatment was only 14.2 weeks, just marginally above Ontario, which had the shortest waits at 14.1 weeks. [95] In the 2015 Fraser Institute report, Saskatchewan’s median wait times was reduced to 13.6 weeks, the lowest in Canada, which was in sharp contrast to Prince Edward Island, which had the longest wait times of 43.1 weeks (figure 3). [96] Similar findings were reported in the 2015 Wait Time Alliance report, which praised Saskatchewan’s “particularly impressive” achievement: in five years the number of patients waiting more than six months for surgery had dropped by 96%. [97]

Figure 3: Median wait between referral by GP and treatment, Canada and Saskatchewan, 2010–2015



Source: *Waiting Your Turn: Hospital Waiting Lists in Canada* (various authors, 1993–2015). Fraser Institute.

[93] Canadian Institute for Health Information (2015), *Wait Times for Priority Procedures in Canada* (April): 7.

[94] Bacchus Barua, Mark Rovere, Brett J. Skinner (2010), *Waiting Your Turn: Wait Times for Healthcare in Canada, 2010 Report*, Fraser Institute: 6.

[95] Bacchus Barua, Frazier Fathers (2014), *Waiting Your Turn: Wait Times for Health Care in Canada, 2014 Report*, Fraser Institute: 1.

[96] Bacchus Barua (2015), *Waiting Your Turn: Wait Times for Health Care in Canada, 2015 Report*, Fraser Institute: v.

[97] Wait Time Alliance (2015), *Eliminating Code Gridlock in Canada’s Health Care System: 2015 Wait Time Alliance Report Card*: 2.

Conclusion

The Saskatchewan Surgical Initiative (SSI) was successful for various reasons. Most important was leadership. In setting a concrete, easily understood target in 2010, the government showed leadership and established the vision and direction that guided the SSI. But well before 2010, Saskatchewan public servants had shown leadership when they became champions for fundamental changes to the way waiting lists were managed and led the efforts to learn from other parts of Canada and the world. Peter Glynn and those involved in the Saskatchewan Surgical Care Network (SSCN) provided leadership in making many of the fundamental changes in the management of wait times that laid the foundation for the SSI.

Leadership also encouraged the engagement of providers and stakeholders and was part of changing the culture of health care. Breaking down the silos and other barriers to change could only be achieved through collaborative, team-based decision-making in which all groups involved in the health-care system were represented. Those involved spoke of an enthusiasm about the process and commitment to success that meant they were willing to spend their time sitting on numerous working and study groups and if needed give up their Sundays for surgery.

Besides the three-month target set by the government, the other driving force behind the SSI was its patient-centered focus. The target, the patient-centered focus and the collaborative decision-making complemented each other. Meeting the three-month target meant moving patients through the complex network of health-care silos in record time, which meant focusing on the patient. Fast-tracking the patient's journey through the system required collaboration and co-operation among health-care professionals and better integration of the system. The result was a change in the culture of how health-care decisions are made and how the system operates.

There were also some surprising elements to the SSI. One was that its main components were not new but had been advocated or implemented before 2010. In health care, the changes that have to be made are usually not a mystery—report after report covers the same ground: better integration, more focus on patients. The challenge is to provide the leadership, focus, determination, and funding to make the required changes a reality. The other surprise was the extent of inter-provincial co-operation and use of best practices. Often the image of Canadian health care is of 10 provincial health-care systems operating in isolation, with only the federal government able to provide national leadership. In fact, the provinces learned from each other, attended conferences together, and joined associations in which they worked together to tackle the problem of wait times. In fact, many of the changes made in Saskatchewan were remarkably similar to those made in other provinces.

It also has to be recognized that the SSI was a success within a specific and limited context. The focus was on reducing the wait times for elective surgery. However, as the Wait Time Alliance recently pointed out, reducing wait times in one area is only dealing with one part of the problem. Some of the many areas that have wait times that need to be addressed include: primary care, mental health services, home care, long-term care, and palliative care. [98]

Moreover, the SSI required an increase in capacity, which in turn necessitated putting more money into a health-care system that is already consuming more than 40% of provincial budgets. The SSI coincided with prosperous economic times when significant resources could be spent directly and indirectly on what was then the province's top health priority. However, recently falling oil prices and other factors have led to spending reductions and there are some indications that wait times might be creeping back up again. [99]

Finally, the SSI did not tackle the fundamental structural problems of Medicare that foster long wait times. There is still no link between patients and the cost of the doctor and hospital services that they use, and with no financial constraint on demand, limiting capacity is still the main tool used by governments to control costs. The coverage is still focused on doctors and hospitals, with limited spending on prevention of disease, and there are still problems with inadequate funding for other more cost-effective services like home care. Though control of waiting lists was centralized, doctors are still the main gatekeepers of the system and moving to a primary health-care model is still a challenge. The SSI was successful in bypassing the structural problems but, in effect, what was being treated were the symptoms—the wait times—not the root problem, the way Medicare is structured and funded.

But the Saskatchewan Surgical Initiative was never designed to cure the problems of Medicare; it was created to relieve the distress and suffering of the patients who were waiting far too long for surgery. In that it succeeded.

[98] Wait Time Alliance (2015), *Eliminating Code Gridlock in Canada's Health Care System: 2015 Wait Time Alliance Report Card: 2*.

[99] See, for example, Emma Graney (2015, October 16), Sask. Govt under Fire on Medical Wait Times, *Regina Leader-Post*, <<http://leaderpost.com/news/local-news/sask-govt-under-fire-on-medical-wait-times>>.

Appendix: Chronology of Reports and Initiatives that Led to the Saskatchewan Surgical Initiative

1990s The Fraser Institute's reports show that waiting lists are long and growing in Canada and that Saskatchewan's are among the longest.

1998 The Task Team on Surgical Waiting Lists created by the Saskatchewan government and more funds provided to reduce wait times.

Health Canada's publication, *Waiting Lists and Waiting Times for Health Care in Canada: More Management!! More Money?* recommended changing the management of waiting lists.

1999 Saskatchewan joined the Western Canada Waiting List Project and worked collaboratively with other provinces to find better ways to manage waiting lists.

2004 Health Accord agreed to by the federal and provincial governments. The federal government committed itself to providing more funding to reduce wait times in five priority areas and the provinces agreed to establish evidence-based benchmarks for medically acceptable waits.

Saskatchewan Surgical Care Network created in Saskatchewan to address the long waiting lists. SSCN laid the foundations for the SSI by creating a centralized registry, prioritization standards, benchmarks for medically acceptable waits and web-based access to lists for patients.

2009 *For Patients' Sake: Patient First Review Commissioners Report to the Saskatchewan Ministry of Health* recommended that waiting lists be tackled expeditiously.

2010 Saskatchewan Surgical Initiative unveiled with the commitment that by March 2014 no patient would wait more than three months for surgery.

2014 Saskatchewan Surgical Initiative ended. There was a 75% reduction in the number of patients waiting more than three months for surgery.

Table A1: The management and organization of wait times before and after the SSI

Before the SSI	After the SSI
<ul style="list-style-type: none"> ● waiting lists managed by doctors, hospital and regional health authorities 	<ul style="list-style-type: none"> ● centralized registry of waiting lists (initiated by the Saskatchewan Surgical Care Network)
<ul style="list-style-type: none"> ● no standards for prioritization 	<ul style="list-style-type: none"> ● standards established for prioritization (initiated by the SSCN)
<ul style="list-style-type: none"> ● patients referred to one specialist 	<ul style="list-style-type: none"> ● pooling of referrals
<ul style="list-style-type: none"> ● paper records of wait times 	<ul style="list-style-type: none"> ● web-based wait times available to patients*
<ul style="list-style-type: none"> ● no targets for treatment, some benchmarks 	<ul style="list-style-type: none"> ● specific target/guarantee for wait times
<ul style="list-style-type: none"> ● lack of integration, collaboration 	<ul style="list-style-type: none"> ● collaborative, team-based decision making
<ul style="list-style-type: none"> ● health care system designed around providers 	<ul style="list-style-type: none"> ● patients first philosophy
<ul style="list-style-type: none"> ● limited communication with the public 	<ul style="list-style-type: none"> ● focus on communications

About the Author

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Janice MacKinnon is currently a Professor of fiscal and health policy at the School of Public Health at the University of Saskatchewan. She has a doctorate and M.A. from Queen's University and an Honours B.A. from the University of Western Ontario. She is the author of three books, *The Liberty We Seek* (Harvard University Press), *While the Women Only Wept*, and *Minding the Public Purse*; she has also written many articles for academic journals and policy publications. Between 1991 and 2001, she was a cabinet minister in Saskatchewan and held various portfolios including Minister of Finance, Minister of Social Services, Minister of Economic Development, and Government House leader. During her tenure as Finance Minister, Saskatchewan became the first government in Canada to balance its budget in the 1990s. She has also served as the Chair of the Board of the Institute for Research on Public Policy and a board member of the Canada West Foundation; she provides commentary on and analysis of Canadian fiscal issues, health policy, and politics. In 2009, she was appointed to the National Task Force on Financial Literacy and from 2010 to 2015 she served as Chair of Canada's Economic Advisory Council. She is a Fellow of the Royal Society of Canada, a member of the Order of Canada, and in 2013 she was chosen as one of Canada's top 25 Women of Influence.



Acknowledgments

The author would like to thank Mark Wyatt for providing important information about the Saskatchewan Surgical Initiative and the anonymous reviewers for their comments, suggestions, and insights. Any remaining errors or oversights are the sole responsibility of the author. As the researcher has worked independently, the views and conclusions expressed in this study do not necessarily reflect those of the Board of Directors of the Fraser Institute, the staff, or supporters.

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Date of issue

April 2016

ISBN

978-0-88975-386-0

Citation

Janice MacKinnon (2016). *Learning from the Saskatchewan Surgical Initiative to Improve Wait Times in Canada*. Fraser Institute. <<http://www.fraserinstitute.org>>.

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