

Health Reform and Wait Times in Alberta

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Introduction

Wait times, across Canada, are a significant issue in the contemporary politics of health care. Since the mid-1990s, the Government of Alberta has attempted a number of different responses to public and provider concerns about wait times for major diagnostic and surgical procedures in a variety of ways: infusions of short term money to address immediate pressure points; system re-organization (such as regionalization, or the use of private providers), developing incentives through the creation and publication of wait time performance measures, and the introduction of a voluntary, electronic, wait-time tracking registry. None of these efforts has solved the wait time policy problem, but the evolution of the government's approach over time represents a visible example of policy learning.

Policy learning, as presented through the literatures on policy communities and the advocacy coalition framework, is best studied, as in this research, through investigation of specific policy areas over a lengthy period of a decade or more (Sabatier, 1993) A basic argument of the literature is that organizations and communities resist learning that goes against their strongly held beliefs and values about the world; in other words, the policy core is most resistant to change but more peripheral policies will be more easily changed in response to new information. Learning which challenges the core practices and policies held by a network or coalition often arises when a policy system undergoes a disruptive shock (Sabatier, 1988; Lindquist, 1992).

This case study is one of six developed in Alberta as part of a cross-province study on the determinants of health reform in Canada¹. These cases collectively cover four policy categories: setting out governance and accountability arrangements, establishing financing arrangements, making program delivery arrangements, and defining program content (Lavis, Ross, Hurley et al, 2002). The case study around wait times is an example of the third category, where the policy issue relates to changes in how health care is delivered. Waits are a public concern for several different types of health care service, including major joint replacements, heart surgeries, diagnostic procedures such as MRIs, long term care, emergency rooms and family doctors. In this study, we look only at the government policy responses related to the first three of these.

Pertinent documents and public records (e.g., media, Hansard) were reviewed to establish the background for the case study. These information sources were complemented with a number of semi-structured interviews with key informants. The data was analyzed using a coding framework developed from the literature that focused on key institutional, idea, and interest group concepts, as well as important external events that may have impacted on or shaped the policy making process. After providing an historical overview of the basic chronology of events, we will examine the case in greater detail within the context of the conceptual framework.

Emergence of Wait Times as an Issue

Some sort of rationing is inherent in any health care system, since resources are always limited relative to demand. Wait lists, in fact, are desirable to maintain efficiency (ADD refs) – if there was never a wait for any service, the health system as a whole would be vastly over-built and consume far too many resources for staff and equipment that would be idle much of the time. However, wait times may have been pushed to unprecedented levels in Alberta as a consequence of the substantial health care funding reductions of the early to mid-1990s. Between 1993 and 1995, provincial health budgets were reduced by 13% (CIHI, 2004); coupled with the introduction of health regions, this

¹ The overall project involved investigators in Alberta, Saskatchewan, Ontario, Quebec and Newfoundland and Labrador, and was funded by the Canadian Institutes of Health Research and Health Canada.

resulted in a significant downsizing of the acute care sector. For example, short-term care beds were reduced from 4.8/1000 persons in 1986/87 to 2.8/1000 persons in 1994/95, or a 35.4% reduction (Tully & Saint-Pierre, 1997); some facilities were closed entirely. In the year between March 1994 and March 1994, 20% of the province's beds vanished (Alberta Health, 1995).

Data collected by a variety of parties since that time shows the emergence and increase in public concern about accessibility of care (Virani, Kanji & Cooper, 2000), rising by the year 2000 to be the number one health care concern. "Access to health care services and waiting times are people's number one concern with the health system" (PACH, 2001a, p.21).

The provincial government has collected its own data on public opinion via commissioned sample surveys annually since 1995. Over the decade, public ratings on ease of access show a consistent decline. As Figure 1 demonstrates, the public grew increasingly concerned with access after the introduction of health reforms, with a notable increase in concern (i.e., a drop from satisfaction levels in the mid 70%-range to the mid 60%-range) in the late 1990s.

Public consultation processes also flagged the growing concerns. In 1997, the Provincial Health Council of Alberta² noted that "concerns were expressed about the effect of health reform on the health of Albertans (longer waiting lists, fewer specialists, etc.)" (PHCA, 1997, p.10). In 1999, the Final Report and Recommendations from the consultation process known as the Health Summit acknowledged waitlists as a continuing issue of importance (Alberta Health and Wellness, 1999). The 2001 Mazankowski Report, reviewing existing data, emphasized that "in spite of significant investments in the past few years, waiting times for selected services continue to be too long and people worry that the health system may not be there when they need it." (PACH, 2001a, p. 21).

The medical profession also focused attention on perceived problems with wait lists by regularly commissioning or conducting its own surveys to gather evidence on the point. For instance, "a 1996 national survey conducted by the College of Family

² The Provincial Health Council of Alberta was established in 1995 under ministerial Order #195/95 (Minister of Health) as a publicly nominated 16 member advisory body "to provide the Minister ... with advice regarding the performance of Alberta's health system and the health status of Albertans, relative to the province's health goals, the Alberta Health multi-year business plan and the regional business plan."

Physicians of Canada showed that general practitioners were ... concerned about the effects of waiting on the health of their patients (College of Family Physicians of Canada, 1996). Almost 70 percent of family physicians felt that the waiting times their patients were experiencing were not acceptable.” (cited by Esmail & Walker, 2003, p. 27) A 1997 Canadian Medical Association poll found that nearly two-thirds of respondents felt that waiting times for surgery had grown and half felt access to specialists had become more difficult; these figures had grown from 53% and 40% respectively just one year before – a growth of approximately 20% and 25%, respectively (Sanmartin et al, 2000). The Report was raised in the Alberta legislature and acknowledged by the Minister of Health., (Hansard, April 30th, 1997, 286). When challenged about its implications, the Minister agreed that wait lists were of concern to Albertans, and cited the government’s efforts to bolster funding for both RHAs and province-wide services (Hansard April 30, 286).

The Alberta Medical Association produced its own survey data based on the perceptions of physicians and the public (1998, 1999). The survey of physicians:

revealed lengthy waits relative to what was defined as a reasonable wait for numerous urgent services, tests and procedures in the specialties of psychiatry and cardiology. Additionally, it was common for one or two services among the other specialty groups surveyed to have waits greater than three times the length of the reasonable waiting period noted by the specialists... Long waits for urgent access to magnetic resonance imaging (MRI) were of universal concern.(AMA, 1998).

In the survey of patients, “more than 80% said they had to wait for the health services they needed. And too often their condition worsened while they waited.”(AMA, 1999) Underpinning the survey data was a large inventory of qualitative statements from patients about their negative experiences with access to health services. Unsurprisingly, the physicians’ remedy for these ills was more investment by government in the health care system.

The BC-based Fraser Institute surveys doctors annually about their wait lists. Widespread media coverage of the Institute’s annual review of wait times in Canada placed increasing pressure on government to respond. (Esmail and Walker, 2003; Hansard, 1996, February 13-August 27, 2171-2178; Committee of Supply, 2223-24,

2232) The headlines in Alberta’s major newspapers since 1993 reflect both the tone of coverage and the government’s response to it: See Appendix. The Fraser Institute used its findings to promote the putative benefits of more private provision of health care in reducing waits – privatization being its policy solution to most every problem.

While there seemed to be public opinion data aplenty, there was less ‘hard’ data on actual wait lists and their impact, if any, on health outcomes. The Provincial Health Council of Alberta made this observation in 1997: “[We have] been unable to find province-wide information on waiting lists for specific procedures and the effects of waiting on people who require health services.” (PHCA, 1997, p.14) The absence of reliable and comparable data was re-stated by the Premier’s Advisory Council on Health several years later: “Although we frequently hear stories of long waiting times, the reality is, we don’t have reliable and consistent information on waiting times” (PACH, 2001b, p. 1). The government has sought out additional data to help it (1) judge whether the problem as reported in these various surveys is in fact ‘real’, and (2) to help it figure out how to manage the issue. Box 1 and figures 2-4 provide information about the establishment and refinement of the province’s data about wait lists and wait times for cardiac surgery, major joint replacements, and MRIs

Comment [UU1]: I put it in a box because it seems to interrupt the flow of the paper otherwise.

BOX 1: The Evolution of public reporting of wait list and wait time data in Alberta

Published wait time data: Heart surgery

Cardiac surgeries in Alberta are delivered in two centres: Edmonton and Calgary. Before regionalization, doctors and hospitals in these cities, along with the formal Provincial Advisory Committee on Cardiovascular Services, gathered information for their own needs, so it was readily available (P1; P36). The provincial committee was disbanded with regionalization. In July 1995, Capital Health (the Edmonton-area regional health authority) published data on both wait lists (number) and wait times (average length in four categories of urgency) for heart surgery in its first Annual Report (Capital Health Authority, 1995). Data was reported back to June 1994, the effective date of health system regionalization. The data showed a lengthening wait list (16% larger in June 1995 compared to a year previous), though time to treatment remained comparable. This data was presented as performance measures, though explicit targets were not indicated. Capital Health continued to report publicly on wait times and a variety of other performance indicators through these reports until 1998. The Calgary Health Region did not begin to consistently include data on heart surgery wait lists and wait times in its annual reports until 1997/98.

Starting with its 1996/97 Annual Report, Alberta Health began publishing its own information on quarterly cardiac surgery waiting lists in Alberta (combining data from the Capital and Calgary Health Regions) retrospective to January 1995 [Figure 2]. This information was included in performance indicator publications targeted to a general public audience from November 2000, and subsequently in the Comparable Health Indicators project publications.

Published data: joint replacements and MRIs

Available data on waits for joint replacement surgery were initially much more sketchy than that for heart surgery. “There weren’t any regional data on the joint replacement waiting list, but that was becoming an issue already in early 1995, so we created some data by contacting the orthopedic surgeons’ offices and just collecting the information about how many were on their lists.” (P36) Capital Health’s 1994/95 performance report included data collected in May 1995 from a sample of patients currently waiting for treatment; it took until 1996 to have a system in place for reporting average wait lengths. Similarly, provincial data reporting was slow to emerge. Alberta Health published data on joint replacement wait times in its annual reports from 2002/03 [Figure 3]. Data initially included Calgary, Edmonton, and the Palliser, East Central and Mistahia RHAs, with the Chinook and DTHR beginning in the second quarter of 1999.

Capital Health began to present data on waits for MRI in late 1995, with data retroactive to January of that year. Again, province-wide data was slowly pulled together from the 5 regions that offered MRIs (Capital and Calgary; Chinook from July 1999, DTHR from April 2000, Mistahia from January 2001), with wait lists published by Alberta Health in its annual reports starting from 2000/01 [Figure 4].

Early policy responses: 1996-1999

In response to the mounting public pressure and the growing evidence about the issue, an additional \$11.4 million in supplemental estimates funding to cut wait times for cardiac and joint replacement surgery and MRI testing was announced by the Premier during a televised address (January 29, 1996). Then-Minister of Health Shirley McClellan

referred to this as “a one-time investment in a set of programs that have been facing unusually high demand in the last few months. (press release, January 30/96).³ Wait times for heart surgery did drop off substantially shortly after the infusion of this cash, although eventually they would rise again (see Figure 2).

In March 1996, Premier Klein and Lyle Oberg (a physician MLA), **Chair of the Health Plan Coordination Project** [?], proposed a Health Charter that would guarantee Albertans access to key health services such as heart surgery and hip and knee replacements within defined periods of time. This was widely seen by the media as “one of the key planks of the party’s re-election platform” (Arnold, 1996). When the Charter was rejected by delegates at a Conservative party policy convention in September 1996, the government was perceived to be scrambling for an alternative proposal. The November 1996 “Action on Health” program ensued. It noted that “Waiting times for critical services such as heart surgeries, joint replacements and specialized tests are too long” and promised additional funding. This was presented as a combination of money for staffing, specialized equipment, and general funding. The province appeared to argue that wait list pressures were due to diversion of funds to province-wide services at the expense of other needs, and so promised additional money for such services to reduce the ‘trickle-down’ effect. The new population-based funding formula was suggested to give RHAs the flexibility they needed to tackle remaining pressure points.

The announcement of the program and related funding preceded the provincial election which occurred in the spring of 1997. Any public concern over health cuts, however, proved to be no real political problem for the government, as the Conservatives were re-elected with a larger share of both seats and popular vote. Concern over access and wait times received regular formal recognition by the government during its next mandate. For example, the 1999 Throne Speech identified improved services for surgeries and diagnostics as one of the priorities in health (Legislative Assembly of Alberta, 1999). In the Government’s response in 2000 – the Six Point Plan -- Point One called for “improved access to quality funded services,” and was backstopped by \$482

³ Despite this claim, announcements of additional “unplanned” infusions of money into the health system seemed to recur about every six months from 1997 through to 2001. [A table showing this would be helpful for the final product. I believe we started one (Timelines?)—perhaps you have it?]

million in new money in the Health budget and an additional infusion of targeted money to reduce wait times in April, May and June of that year.

Some politicians and private interests advocated increased private for-profit delivery of health services as a means of addressing wait lists. The strength of this sentiment was most clearly expressed in 1998 through the introduction of Bill 37 and the subsequent revised version, Bill 11 (2000). The Premier expressed the underlying logic of privatization as it related to the wait list issue:

the Calgary regional health authority announced that it was contracting out for the services of privately operated MRIs. They're doing this to reduce waiting lists and to make it easier and more accessible for people who need MRIs under insured services to get there much quicker. (Hansard, March 6, 2000, 499-500)

Academic literature generally rejects the accuracy of this argument (Cite refs from CHSRF Mythbusters). Intense interest group mobilization against this policy meant that it never became accepted as the solution to the wait list issue. (For more on the debate over privatization of health care service delivery in Alberta at this time, see Church and Smith, 2006.)

In August 2000, the Government established the Premier's Advisory Council on Health (the Mazankowski Committee) to provide advice on vision, strategic framework, approaches and sustainability. Once again, an underlying theme of the report was access to health services. Mazankowski recommended implementation of an electronic internet registry of wait times information, centralized surgical bookings, and 90 day "care guarantees" for major procedures. In 2003, the Government announced plans to implement a voluntary electronic wait list tracking registry. Pilot projects for some centralized booking, eg., in orthopedics, were subsequently launched. The notion of care guarantees was ultimately abandoned,

Having outlined the case in general terms, the remainder of the paper will address the role of institutions, ideas and interests in shaping the policy choice.

Institutions

The devolution of responsibility for many service planning and delivery responsibilities to health regions and the subsequent significant reduction or elimination of staffing in many program areas left the Ministry with little capacity or expertise about the day-to-day workings of the health system (Church and Noseworthy, 1999).⁴

I would say there was a very crude understanding of the nature of the waiting list problem and I think that largely can be attributed to the fact that government during the few years leading up to that had seriously downsized their own ranks.... Very few people left with clinical backgrounds, for one thing, very few people that had solid knowledge of even the management workings within a region or a hospital of how these things actually happened (P36).

Ongoing turmoil within the downsized department further contributed to challenges in grappling with policy issues such as the emergence of wait times as a public concern. Between 1994 and 2004 a total of eight Deputy Ministers were rotated through the department. Several reorganizations of the department also occurred. “The senior management kept changing and we would spend more time reorganizing and having new deputies and briefing new ministers than actually dealing with issues.” (P5; also P33, P36) After 2000, when the entire senior executive was replaced, corporate memory and expertise in health policy became a significant problem.

As the lack of reliable data became seen as a serious impediment to any effective policy response, Alberta Health created (in 1996) a specific unit to address the issue – Standards and Measures Development – under a newly created departmental branch. Initially, Alberta Health argued that focusing directly on wait times, a conceptually “messy” problem was not a good idea and unlikely to succeed (P33). Developing a better understanding of the problem by accessing existing data or creating new means of acquiring data was a necessary first step. In the late 1990s one important project was the effort to develop some standard definitions, but with flexibility, so that they could begin collecting and publishing quarterly data on wait times in key service areas.

⁴ In contrast, Saskatchewan had attempted to maintain its Ministry’s capacity, in part because they started with a large number of Districts (32), which themselves did not have much more capacity than the previous hospital boards. Thus, the ability of the Ministry in Saskatchewan to act in a more directive fashion on the wait list issue was enhanced. (P36)

[WCWL here briefly: Its objectives are to develop better measures of wait lists and to create tools for prioritizing patients. Thus this fits with the interests of the Standards branch.]

Outside of the Ministry, the reorganization of governance and management structures to create regions meant that a large cadre of senior hospital managers (CEOs) was eliminated. In general, the loss of experienced personnel throughout the system reduced the capacity of the system for quality assurance, management and clinical service delivery. However, as resources were brought back into the system the regions were able to acquire the necessary expertise to better address issues such as wait times.

The introduction of regional structures however also had the effect of allowing the problem to be understood in a new way – the kind of system shock that is often associated with opportunities for policy learning. Where under the old system, the existence of wait times was only understood at the level of individual physicians or facilities, the introduction of regional governance and service delivery structures facilitated recognition of the problem as systemic in nature. “The shared concern, I think, galvanized around the ability to look across organizations, and that was once we actually got regionalization established, and now multiple facilities were a part of the same entity and it became more apparent that there was a problem between the supply and the demand equation.”(P1, see also P8) Consolidation and planning under the newly formed health regions was viewed as a possible way to reduce wait lists. (Hansard, May 3, 1995, 1503-1509).

Ideas

The focus on fiscal accountability during and after initial cutbacks, and the introduction of devolved funding for health regions, necessitated some form of accountability measures be developed and enforced, to avoid slipping into a pattern of simply throwing money back into the system. (P5) Business planning and performance targets began immediately after the introduction of health regions (Goodkey, 2001; Peach, 2004). Although initially fairly crude, a range of standard performance indicators, including some for wait times, was developed. (P36) Accountability itself was tied to the

Comment [UU2]: I had to take a lot of the accountability text out as it was word-for-word the same as text in the regionalization paper.

reliable data issue in that meaningful accountability measures could not be developed until “we knew we could get access to reasonable data.”(P33)

Another idea that strongly influenced the government’s stance on wait times as a policy problem was the Conservative ideological commitment to solutions that maximized individual personal choice and responsibility. Early thinking on this is apparent in comments made in 1995 by then Minister of Health Shirley McClellan: “We do encourage people, if they are waiting a long time, to ask their surgeon if they might consider referring them to someone else with a shorter waiting list or that they look at perhaps having that procedure done in another area” (Hansard, May 3, 1995, 2197-98).

In similar terms five years later, the PACH gave the following rationale for its recommendation to posting wait time data on the internet:

Instead of waiting on an *unknown* [our emphasis] list, patients would have access to waiting times for selected procedures for each hospital and each physician in the province. People could check the website, then could consult with their family physician about getting referred to another physician or facility in their region or in another region with shorter waiting times.(PACH, 2001a, p. 44)

Once the wait time registry was running, it may not necessarily have led to changed behaviour by the public, but from the government’s view it was perhaps almost as good that people felt better about waiting as long as they did:

patients seemed very pleased about the choice for a shorter wait time with a non-preferred provider; they liked the idea of being able to make that decision, and they often chose the longer wait time but then they’d be satisfied because they had had the choice.(P33)⁵

Interests

Physicians, as the main providers of the services for which waits were a concern, and as advocates for their patients, were the interest group which most obviously played a part in the policy community around this issue. Individually and collectively, doctors

⁵ In addition, this might be attributed to the rhetoric associated with the privatization debate, in that the government argued that privatization would give people more options for care while reducing wait times for services provided through public facilities.

brought forward information, such as the surveys described earlier. As well, many letters from the public were received by both Alberta Health and Wellness and the Regional Health Authorities. The wording of these letters, -- “I was speaking with my physician and he suggested I write to you about wait times...” -- indicated that patients and physicians were interacting with each other on the issue. As another example, in late 1996, the Capital Health (Edmonton) Medical Staff produced a report documenting a variety of “problem areas”, including “access to care and resources” and “quality of care”. Within this, “long waits” were identified for specialist referrals, pediatric rehabilitation, audiology, orthopedic surgery, emergency rooms and other procedures. Many of these wait time problems were attributed to shortages of staff and resources (Region Ten Medical Staff, 1996).

At the same time, physicians resisted any policy solutions that would interfere with their historical clinical autonomy (the ‘Medicare bargain’). For some, the proposed electronic registry was such a threat, and in parts of the province, these specialists resisted involvement in any efforts to develop standardized wait lists:

They didn’t even want to provide their wait time data to the region – and the regions were very reluctant to use their authority. Our understanding is that in Ontario and elsewhere too...that if physicians did not agree to provide their wait list and wait time information, they were in jeopardy of losing their OR time because the regions were making that OR time available to them.(P33)

The province took care as much as possible on this issue not to alienate this powerful stakeholder group:

I think with this issue, it was ‘go extremely slow’ and as we learn things, maybe we’ll take the next step, but we don’t want to upset any of the major parties involved here, especially the physicians, and let’s see what happens in the rest of the country, and in the meantime, let’s get the information we can, but we aren’t going to push too hard to get all of it. (P33)

The Alberta government response to wait times as a case of policy learning

The initial response from politicians to the issue was to allocate additional money during periods of increased public pressure (when lists grew beyond what was publicly acceptable). In part, this reflected a somewhat simplistic understanding of the issue. As one participant characterized this understanding, the politicians perceived the issue as one of a shortage of money resulting from expenditure reductions. From the politicians' point of view, if money is the issue, why won't putting money back into the system fix the problem? From the point of view of politicians, the infusion of money was something that they could do fairly quickly and visibly, a policy lever that they had not given away to health regions. (P36) It was a good response in some ways as well to media and professional pressures. And immediately following regionalization, both the department and the new health authorities with limited policy capacity were not really in a place to counter this viewpoint.

Policy learning occurred as increased infrastructure was devoted to the issue. For example, by 1997, the Government response began to shift to talking about the establishment of performance measures and standards: "we are establishing standards to make sure that waiting lists are brought to, generally speaking, medically required or accepted limits." (Hansard, April 30th, 1997, 286). This links to the work on accountability and performance measures that had been on-going in Alberta Health, as part of the overall business planning process that had been adopted across government.

Elected leaders, likely guided by civil service advice, gradually began to present a more nuanced understand of how spending ought to be targeted in order to address the factors that were shaping the wait list problem

Mr Speaker, again, there are a number of different inputs that will help us reduce waiting lists: the people -that is radiation therapists in this case- equipment, and of course places for these people to work. People, plant and equipment are the three inputs that have helped reduce waiting lists in this province.(Hansard, November 16th, 2000, 1942)

The issue of wait times was brought into sharp focus for all the key stakeholders through the Mazankowski report.

in my view the Alberta Government really didn't get it that they had a serious problem with waiting for services, at least elective services. They knew they always had a problem with emerg, okay, getting into emerg, but I don't think they really got it on the elective services provision side until the Mazankowski Report galvanized the view.(P1)

Ninety-day care guarantees, centralized booking and posting wait times on the Internet were recommended as ways of addressing the problem (PACH 2001a, p. 43). Mazankowski was high profile, but little apparent research was evident in its report. One of the very few references cited by PACH was a study of the use of the Internet to "empower" Swedish consumers in the area of waitlists, commissioned by a think tank in Manitoba. This seems to have influenced the thinking about an Internet-based registry and its purpose (Hjertqvist, 2001).⁶ None of these ideas was really new, since they had been floated in government and bureaucratic circles since at least the mid-1990s and the emergence of wait lists as an issue. In some ways, the Mazankowski recommendations built onto the internal work that had been occurring. (P15) For instance, the idea of a registry was discussed within the bureaucracy at an early stage, but it was felt that the underlying data requirements precluded any serious consideration at the time. It would be meaningless to offer wait time data for individual providers until it was certain that all (or almost all) physicians were participating and the information was being collected in a standard and consistent way. Care guarantees, as noted above, had been raised and rejected as a response in 1996. By the time Mazankowski arrived, targets had been developed for breast and prostate cancer and four categories of cardiac surgery. Mazankowski would see this expanded to 20 procedures. (P33)

The Mazankowski Committee operated independently of the ministry, reporting directly to the Premier's Office, and the emerging recommendations were based more on representations from major stakeholders and a review of experience in other jurisdictions (Sweden and New Zealand) than on Ministry input. The Ministry became more involved when recommendations had been made and the focus shifted to implementation feasibility. (P36) Here the most problematic proposals were 'tamed.'

Comment [UU3]: Might there be something here from the somewhat critical coverage of the pace of implementation offered by John Cowell's HRTI?

⁶This document was perhaps brought to PACH's attention by Council member Brian Crowley, who along with Hjertqvist was an advisory member of the Winnipeg based Frontier Centre for Public Policy.

The notion of a 90-day care guarantee emerged through a discussion about how to develop some measurable outcomes that could then be used to hold health regions more accountable for what they were contracted to do.(P34) However, the concept lost its lustre once the potential political and legal ramifications of care guarantees became more apparent.

Before Mazankowski, the public discussion was primarily about targets (i.e., desired results) not about guarantees or standards (i.e., minimum requirements). Within government, it had been clear since the mid 90s that the government did not want to commit to access standards—the main concern was not knowing what the costs would be to meet the standards. In addition, it became clear that for a variety of reasons, there will always be individuals who can't be treated within the desired time frame. (P33)

Over time, the language shifted, with care guarantees being softened to access targets. The number of procedures for which targets have been developed has also been narrowed, in part because of the practical necessity to start somewhere (P1). An Access Standards Committee has been struck, including representation from the College of Physicians and Surgeons, the Alberta Medical Association, the Alberta Association for Registered Nurses and the health regions. (P8, P36). This is evidence of the government re-establishing linkages to the broader policy community in a process of collective learning.

Interprovincial diffusion of innovation

Diffusion of policy innovations across provinces also impacted on the choice of policy options in Alberta. Alberta had been slower than some other provinces in building the technical infrastructure for tracking wait times; thus it could learn from what had been done previously in places such as British Columbia and Ontario. In deciding on which specific approach to choose, Alberta looked at other jurisdictions and opted for the British Columbia approach to the on-line registry: (P8)

Comment [UU4]: There is probably a body of literature on this topic to draw on.

They [BC] were ... developing data on wait times that would be available on-line, and I believe where they first got wind of that was in either Australia and New Zealand, I think it was New Zealand, where they had

this information online and it was available to physicians and patients. Then they could consult on whether the patient wanted a referral to a different specialist, or maybe go to a different town, or if they preferred to wait. So BC was moving in that direction...[Alberta Health] was bringing people in from BC to make presentations to senior management here, about how it was working there. [Alberta Health] saw that as the way to go. (P33)

Alberta learned from BC that the technological solution was relatively straight forward. The bigger challenge lay in building consensus among major stakeholders about implementation of the solution. In this respect, the major difference between BC and Alberta was that BC had taken five years before it started posting wait times, whereas Alberta was expected to be up and running in 18 months. BC had also hired physicians in-house to work with practitioners to manage wait times, something Alberta has never done. (P36, P8).

The Ontario Cardiac Care Network was one of the earliest examples of developing wait time indicators around specific procedures. The early work of the Cardiac Care Network in Ontario and subsequent work by WCWL on wait time indicators served as the basis for the access standards (prioritization protocol) developed around coronary bypass grafting, one of the first set of guidelines announced by the Ministry. As early as 1996, the Review of Province-wide Health Services in Alberta had cited the cardiac waiting time standards developed by David Naylor, the Director of the Institute for Clinical Evaluative Sciences in Toronto (Alberta, 1996, Appendix 4). In the late 1990s, when Alberta Health began to produce reports for the Minister on cardiac waiting times, they often went on the Ontario website to do some comparisons with the targets that they had set. (P36)

Discussion

The Ministry was instrumental in the initial and subsequent framing of the wait times issue and the resulting policy learning that occurred among elected officials. Alberta Health had argued initially for a focus on the availability of meaningful data and the development of targets, rather than other possible focuses, such as care guarantees. From this approach emerged a better understanding of the problem and the eventual

Comment [UU5]: Perhaps this might best be combined with the previous section

decision to develop a voluntary provincial wait time tracking registry. Ministry officials were also instrumental in developing the policy tools that would support the implementation of this registry. Finally, the work of the department undoubtedly contributed to the increased recognition of the complexity of the issue and the nature of the solutions – increased human resources and plant.

Inherent in the decision to create the voluntary registry was the underlying political culture assumption that government policy should avoid being exceedingly coercive or prescriptive. (P33, P36, P8) In other words, government should seek voluntary cooperation from major stakeholders, rather than imposing a solution. This stems from two policy legacies. The first policy legacy is the “weak state” approach to health policy in Alberta (Boase, 1994). Historically, Alberta has been reluctant to adopt a state-centred approach to health policy (Church and Noseworthy, 1999). During the run-up to the introduction of national medical care insurance, the Social Credit Government under Manning led the opposition to the compulsory federal medicare scheme (Barr, 1974, p135). The Government of Alberta made its position perfectly clear in its submission to the federal Royal Commission on Health Services:

We believe that only by maintaining a system in which private enterprise and individual initiative and personal responsibility combined with whatever financial subsidization is required from society collectively, can the best interests of our people in the field of health be successfully and adequately served. (Submission, p4)

This residual view of the role of the state in social policy has continued to permeate government thinking around social policy in recent years (Bella, 1978, Guest 1997).

The second policy legacy relates to the original physician bargain. As previously described, individual surgeons controlled their own wait lists and were not in all cases willing to surrender that information to the health regions or government. Thus the notions of *requiring* physicians to share data from their wait lists or establishing a system of centralized booking at the provincial level (per the Mazankowski recommendations) were not politically feasible. The fact that data was non-standardized and controlled by various stakeholders in the system made a voluntary approach the most feasible. (P36).

At a more technical level, the choice of the voluntary wait-list registry was the result of the recognition that there was not consistent information on wait times for major surgical and diagnostic procedures.(P8) For example, while Alberta Health did have good data in some areas, such as heart surgery, where only two hospitals in the whole province were providing the service and had been collecting their own data, in other areas, such as joint replacement and MRIs, where seven regions were doing joint replacement (in some cases at multiple sites), there was little consistency in how data was collected.(P36)

Thus, the goal/purpose of the registry was to present standardized information in a way that decision makers and the general public could understand.(P8) In choosing to post wait times at the 90 percentile, instead of the average wait time, Alberta hoped to present a more accurate picture (especially to the public) of what actual wait times might be:

So now we have detailed information on waits, we have consistent data definitions, we have compliance with the majority of physicians who are contributing and we are working at compliance with the rest of them so that the data are really accurate...That's part of what we wanted to do is make it relevant to the public.(P8)

Most provinces have chosen to use the average wait time. Another key difference in the policy choice seems to be that Alberta's data covers the time from 'decision to treat' to received treatment, while other provinces' data covers the time from 'scheduling surgery' to received treatment.

From an implementation perspective, the political imperative was to make the information publicly available as quickly as possible, under the assumption that a public discussion would evolve.(P33). Thus, the policy choice was motivated by a desire to find something that was already developed and could be up and running quickly (P36, P1)).

Conclusion

During the mid-1990s, the Alberta public and thus the Alberta government became increasingly concerned with the issue of wait times. Although access to services is always an issue in health care, initial health reforms, which included significant expenditure reductions and organizational restructuring, contributed to increasing wait

times for surgical and diagnostic procedures. The policy choice to introduce a voluntary, Internet-based wait list registry was influenced by institutions, ideas and interests.

The cut-backs that occurred between 1993 and 1995 created a shortage of physicians and nurses through lay-offs and decreased funding for post-secondary health sciences education. In particular, nurses who were essential to staff beds associated with surgery were in short supply. The significant downsizing and reorganization of bureaucracy at the provincial and local level created a significant policy capacity issue, especially at the provincial level. The loss of human resources, organizational memory and policy expertise meant that the ability of the government to respond to the issue in a meaningful way was delayed. As resources were reintroduced into the system, bureaucratic capacity at both levels was gradually restored, although provincial bureaucratic capacity has probably never been fully regained. Within this context, the relationship between provincial bureaucrats and elected officials had chilled significantly. In particular, the political executive exhibited a disdain for Alberta Health officials.

Although there was a significant level of distrust between these two interests, the bureaucracy did play a significant role in assisting politicians to better understand the issue. While initially politicians understood the issue as a shortage of money, provincial bureaucrats argued successfully that the issue was complex, including a lack of reliable and comparable data on wait times, a shortage of equipment, and a shortage of human resources. As evidenced through debates in the provincial legislature and decisions made about resource allocation, both within the provincial bureaucracy and at the regional level, politicians did come to understand the complexities of the issue. Over time, the information available to politicians shifted from media reporting, polling and anecdotal letters from constituents, to performance measures on appropriate wait times developed by the bureaucracy through the experience of other jurisdictions and the increased integration of expertise from the department and the field. The drive to develop performance indicators stemmed both from the policy learning about the specific issue and a more general push by the Alberta Government to implement a business planning model, including measurable performance indicators at the departmental level.

Physicians played a significant role in shaping the final policy choice. Collectively, professional associations at the national and the provincial levels

documented the extent of concern about the issue among the profession and the public. At the regional level, the medical staff in Edmonton documented the extent of problems with one of the two major health regions. This was supplemented by data on wait times publicly released by the health region.

At the individual level, physicians encouraged their patients to make the government aware of their concerns about access and wait times. Some physicians enjoyed unprecedented access to senior political decision maker. Of even greater importance, individual surgeons controlled the information on their wait lists. In some cases, they were not willing to surrender that information to either the regions or the provincial government.

Within the broader historical context, for at least the past 50 years, the prevailing ideology shaping politics in Alberta has given preference to minimal government intervention in social policy, personal responsibility and choice, and a strong role for the private sector. All of these ideological elements were apparent in the case of wait times. The choice of a voluntary, Internet-based wait-times registry reflects the interplay of these various policy influences. The underlying logic of the registry was to provide all stakeholders, including patients, with accurate and understandable information. In turn, patients and/or their physicians would be able to make appropriate choices about the best way to access the necessary services. The voluntary aspect of the registry ensured that individual physicians were not coerced to surrender control over local information about wait-times. It also recognized the disparity in data collection capacity across different regions and around different surgical and diagnostic procedures. Finally, in taking a voluntary approach the Government avoided a state-centered approach. Activities occurring in other jurisdictions provided Alberta with the necessary policy tools to respond within the boundaries of the various policy legacies and emerging contingencies with which political decision makers were presented. The boundaries within which a policy choice could be made necessitated an incremental approach to policy development and implementation.

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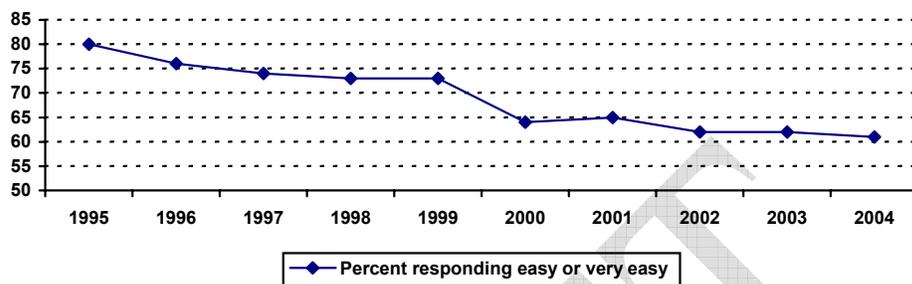
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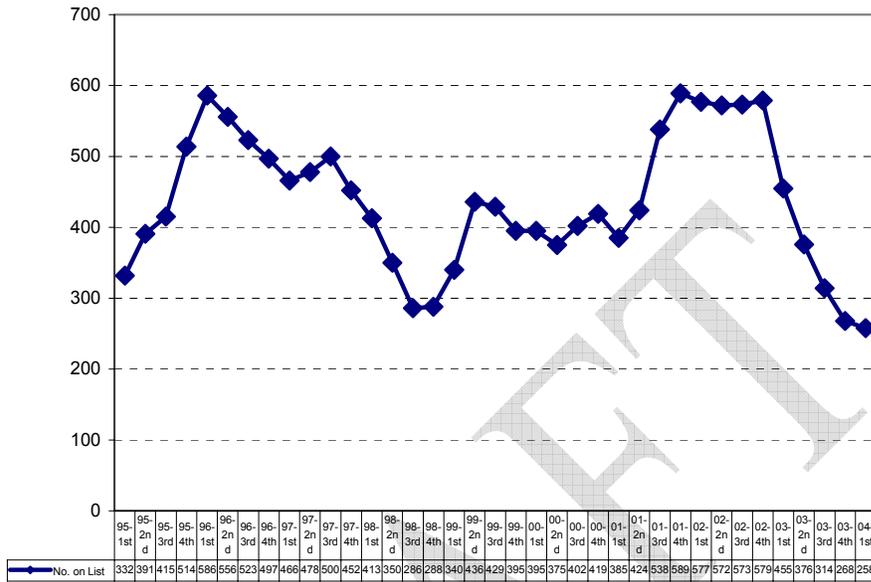
Figure 1: Percent of Albertans reporting access to health care as “easy” or “very easy”, 1995-2004



Source: Alberta Health, *Public Surveys about Health and the Health System in Alberta*, 1995 through 2004.

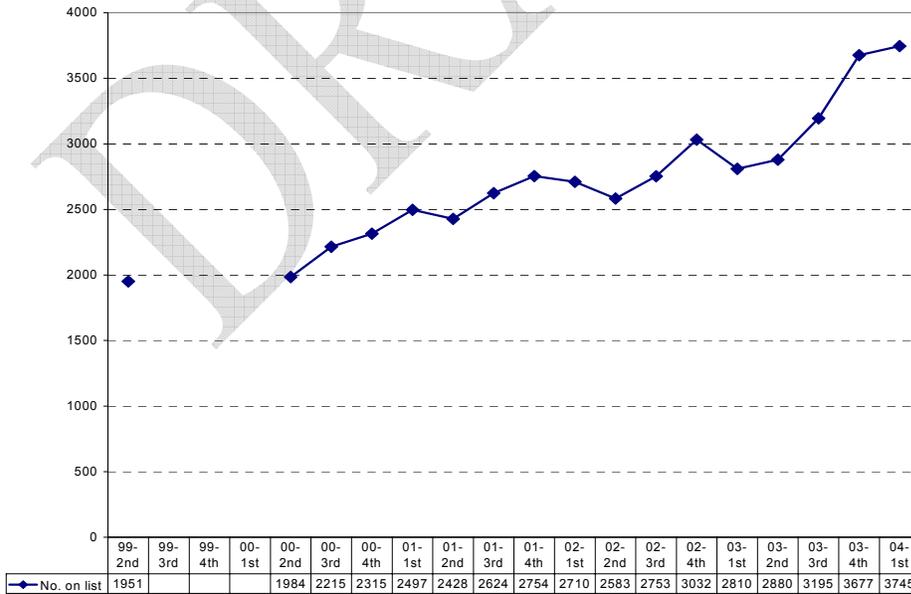
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Figure 2: Patients waiting for cardiac surgery



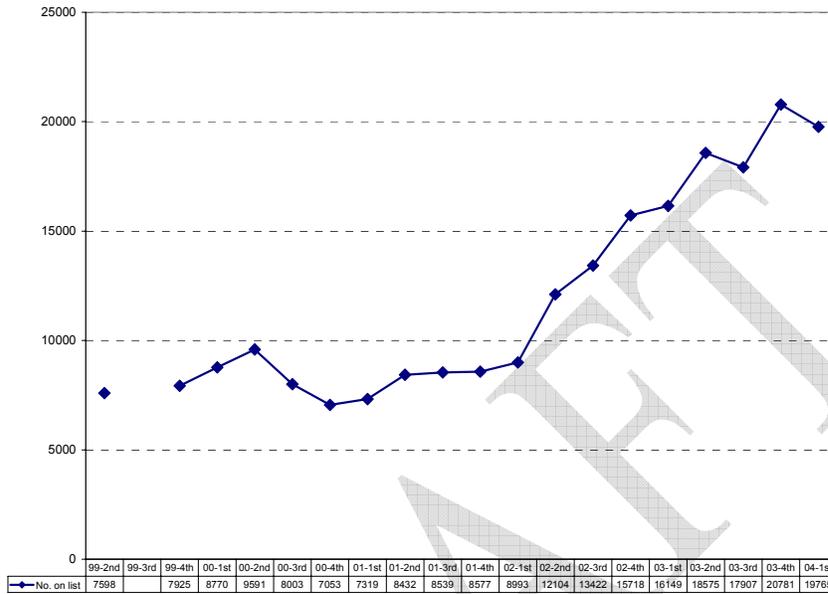
Source: Alberta Ministry of Health and Wellness Annual Reports, 1996/97 to 2003/2004

Figure 3: Patients waiting for hip or knee replacement



Source: *Alberta Ministry of Health and Wellness Annual Reports, 1997/98 to 2003/2004*

Figure 4: Wait lists for MRI



Source: *Alberta Ministry of Health and Wellness Annual Reports, 1997/98 to 2003/2004*

Media Coverage of Fraser Institute Wait Time Reports

Year	Paper and Date	Headline
1994	CH Aug 17	Canadians face long waits
	EJ Aug 18	Waiting-list report called 'misleading'
1995	CH Jun 28	Surgery waits grow shorter
1996	CH Aug 1	Albertans on longest waiting list
	EJ Aug 2	Waiting list stats wrong, Jonson says; 'Problem already recognized'
1997	EJ Jul 26	Albertans waiting longer for hospital treatment; Waiting lists don't tell the real story, warns economist
	CH Jul 26	Alberta patients waiting longer: survey: Provincial health officials claim report is flawed
1998	CH Aug 13	Wait for specialists gets longer: survey
1999	EJ Sep 16	Albertans wait longest for MRIs, brain surgery
	CH Sep 16	MRI wait list worsens: survey
2000	CH Oct 12	Hospital wait times lengthen to 14 weeks
2001	CH Sep 26	Health care delays grow: Survey finds waiting lists surging in last two years
2002	CH Sep 19	Surgery wait-lists lengthen: Median wait 17.5 weeks in Alberta
	EJ Sep 20	Albertans have longest waits in Canada for heart surgery - study: Capital Health disputes study's data collection, points to survival rates
2003	CH Oct 21	Health care delays growing
2004	CH Oct 20	Patient waits up 8 weeks since '93
2005	EJ Oct 19	Patient wait lists still long despite infusion of cash:

CH=Calgary Herald, EJ= Edmonton Journal