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In response to the issue of waiting list management in Quebec, policy-makers decided to implement a computerized service access management

, Autumn 2001, p. 1). Access to this database is limited to health professionals[1].

The SGAS system, originally designed to include all waiting lists and to be administered centrally, functions at present as a management system for hospitals and a tracking system for the Ministry of Health. While use of SGAS is not strictly necessary, the program has been installed in all hospital institutions where tertiary cardiology and/or radio-oncology surgery is performed.

Thanks to access to the computer database, hospital workers can garner exact knowledge of the number of patients waiting for treatment, the severity of each case and the average wait time for a given treatment. The system therefore allows a hospital to prioritize cases according to predetermined factors. It also identifies the number of patients who are not treated within delays defined as clinically acceptable.

An advantage of SGAS for patients is that it provides patients with the confidence that they are receiving fair treatment with respect to the delay in access to care

As far as hospital institutions are concerned, the system allows for greater transparency and equity in the management of priority of access to treatment. Furthermore, hospitals are in a position to better manage the flow of patients, permitting better engineering of the availability of operating rooms and treatment rooms. Because the system makes it possible to compile relevant statistics, hospitals can also assess their capacity to respond to the demand for services. Lastly, the data can be used to justify improvement projects or other strategies designed to offer the required services. (Public Information Office of the MHSS
, Autumn 2001, p. 3).

[1] Apart from the data compiled by SGAS, the MHSS also publishes online the state of waiting lists for sectors other than cardiac surgery and radio-oncology. Statistics for these sectors originate with the MHSS, which compiles the statistics manually from the data sent to to the ministry monthly by the regional agencies. Statistics on tertiary cardiology and radio-oncology are generated and recorded in the SGAS system.

With respect to various health care agencies and the MHSS, the SGAS facilitates the compilation of statistical data for clinical or epidemiological purposes or for purposes of quality assessment.

was deprived of its most experienced professionals, those who also had the best knowledge of the health care system. This phenomenon contributed directly to the increase in wait times.

With a view towards capping expenses, hospitals tended to restrict access to the technical wherewithal for expensive surgery. Furthermore, in order to spare the use of personnel, the frequency of operations was decreased, reinforcing the creation of waiting lists. In this way, the management of resources both human and material had direct consequences on the capacity of the system to care for the ill. The waiting list thus became a means of managing expenses in the public system. Between 1995 and 1998 and up to 2003, the number of operations in Quebec had begun to drop, explaining in part the growth of waiting lists.

Notwithstanding the above, cuts to emergency services had been less

2. The goals

The principal goal of the plan was to increase access to surgical care. Sub-goals for more specific objectives were as follow:

- Reduce wait times:

    Reduce wait times for general surgeries by 50% over the next year. This objective became the priority for the health care system, for all Regional Boards and all hospitals (p. 4).

Management in Tertiary Cardiology was already studying these specialties

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The group conducted visits of operating rooms. Together with experts in each specialization and sub-specialization, it evaluated the workings of the operating team in an attempt to identify problems and difficulties. It then produced a report on its findings and met with the various participants concerned within the hospital. An evaluation of the activities of the group, however, revealed that in fact it conducted very few operations of this nature.

2. Problems encountered

Indeed, instructions given by the authorities of the MHSS stipulated that the Support Group only undertake internal investigations at the request of hospitals or the Regional Boards. This approach was justified by the fact that the ministry wished to respect the respective mandates of hospitals and Regional Boards (in order to not ruffle feathersé). This situation, however, limited the groupís potential for participation.

It is also noteworthy that the group disposed of no financial means of provoking, inciting, or forcing change within institutions, in contrast to the Tactical Intervention Group for Emergency Units (implemented at about the same time at the Support Group). The principal mandate of the Support Group was to develop a tool to compile summary data on waiting lists, but it had neither the mandate nor the resources to develop a computerized management program.

3. Conclusions

3.1 Organizational problems

Over and above the lack of financial and material resources, many problems were attributed to the organization, the operation and the leadership exercised within operation rooms. The work was largely performed behind closed doors. The world of surgeons and operating rooms is an exclusive environment with little transparency. Some operations were controlled by certain groups of individuals or certain interests. It became apparent strong resistance to change was in play, and that institutions themselves were reticent to change. The lack of resolve by institutions to implement the recommendations of the Support Group was in large part due to pressure

groups that did not wish to modify their habits and structures. The Group was thus made to understand that notwithstanding any scientific rationale, the reality on the ground must also always be considered as part of an attempt to provoke change.

3.2 Poor computerization

The Group remarked at what point operating units were poorly computerized. The most basic information was simply not available. At the time, the digital management system OPERA was coming online, but it required considerable investment on the part of institutions, which were also struggling with significant budget cuts. For that reason, few institutions chose to invest in the technology.

monitoring system. Accordingly the Regional Board put together a monitoring and management system of waiting lists for heart surgery on the computer system of the health network, using Lotus Notes.

2.3 The results

The system was abandoned given the announcement by the MHSS of the deployment of SGAS. Rather than mandate the Regional Board of Montreal, which had already acquired some experience in the domain, to develop the SGAS project, the MHSS awarded the contract to the Regional Board of the Bas St-Laurent, despite the fact that the institutions of this Board did not perform heart surgery. The Regional Board of Montreal thus found itself without a waiting list management system for some time.

SECOND SUB-PERIOD:
1999-2003 ð IMPLEMENTATION OF THE SYSTEM TO MANAGE ACCESS TO CARE (SGAS)

1.

- Develop similar criteria for all surgeries for which there were waiting lists[4]
- Rapidly identify patients whose wait times for treatment had exceeded acceptable periods, taking into account that being on a waiting list was not harmful in itself as long as the operation took place within the acceptable delay.
- Improve management of surgery priorities. Until then, the priority for surgeries had been determined by surgeons: SGAS was designed to relieve surgeons of this task, by taking into account pre-established criteria for the ranking of cases and by establishing a schedule for operations that would maximize the number of cases treated within the available time.
- Make the circulation of patients more efficient by allowing referring physicians to better choose the hospital to which to refer their patients, by means of comparing waiting lists between institutions.

b) Collect clear and reliable data

Because the data compiled lacked timeliness and reliability, the MHSS did not have the means to counter the assertions made by interest groups and the media. It was becoming urgent that the ministry dispose of clear and reliable data, in order to respond to public criticism.

Standardization in the compilation of the data would make it possible to evaluate waiting list management performance as well as quality of care, and to compare the results between hospital institutions. The system would also allow for the dissemination of comparative information towards hospitals, a departure from the present state of affairs, where there existed only a one-way flow of data from the hospitals towards the ministry, with no information going back to the hospitals in return. It was hoped that the data could, in fact, be shared. The system would also reveal whether investments made to increase the number of surgeries performed, had been successful.

[4] Basic deliberations took place in order to determine what constituted reasonable delays in access to treatment.

1.2 Sources of inspiration

Sources of inspiration were multiple. To begin with the Canadian context, the experience of Ontario's Cardiac Care Network was a primary source of inspiration. Saskatchewan's provincial registry as well as the Western Canada Wait List also influenced the Quebec model, as did the experiences of some local institutions that had experimented in waiting list management and data collection. The remainder of the sources of inspiration came from the international literature on waiting list management and the NHS in particular.

2. The SGAS project reorganized ð tertiary cardiology (2001-2003)

In March 2000, Pauline Marois decided to reorganize the SGAS project. Rather than develop a management system for the entirety of services for which waiting lists were in existence, the minister announced her decision to prioritize the development of a system for tertiary cardiology and radio-oncology.

Why the decision to reorganize the project and prioritize tertiary cardiology? Several factors motivated the choice to begin with an access management system limited to access to tertiary cardiological care:

To begin with, certain difficulties were anticipated. During the development of the first SGAS project, it had become apparent that a certain number of problems had arisen from the decision to undertake the totality of waiting lists at the same time. It was difficult to unite all medical specializations at the same time, and to come to an agreement on a common prioritization grid, given the different means of care for different pathologies and the variability in customary practices between physicians. Furthermore, physicians were in general resistant to the introduction of codes of best practice. Rather than risk delays or even see the project abor (s)-3(ame)]e5.17 Tm siansian

experiment could, furthermore, impart important lessons for the implementation of the system in other specializations.

The state of the waiting lists in heart surgery and the unique nature of this specialization made this discipline an attractive choice. On one hand, heart surgery patients and radio-oncology patients constituted the most dramatic examples of waiting list subjects; on the other hand, the waiting list in tertiary cardiology is a list of homogenous patients (only one kind of patient) all awaiting the same kind of surgery, which facilitates case management. Tertiary cardiology is also a wise choice to iron out difficulties in a management system because it is a relatively confined discipline with a limited number of participants and locations of practice; surgeons in the specialty know each other well and work well together.

In addition, media pressure and the professional organizations continued to make themselves felt by exploiting the dramatic and emotional aspects of the issue. The Quebec Network for Tertiary Cardiology had just been implemented. The network, which included physicians, was expected to conduct analyses of waiting lists, the evolution of diseases and other subjects, in order to submit recommendations for the deployment of surgical technology: a mandate that could only be accomplished if the group disposed of valid, reliable and timely data. The SGAS would be in a position to provide this data.

Finally, from a financial point of view, the MHSS lacked the human and financial resources to implement a system to manage the lists for all specializations. The difficulties experienced by the ministry up to that point had pointed up the limits of its budget for the development of the computer program.

As a result of the above, the original plan to acquire tools for the management of waiting lists accumulated significant delay. Between 1995 and 1998, the MHSS put pressure on institutions to acquire the OPERA software program. Implementation of the new SGAS system in tertiary cardiology was scheduled to begin in 1998, with implementation for other types of surgeries to follow. Because the situation was supposed to be temporary, investments for other waiting lists had been shelved. The application of a computerized tool was thus put off from one year to the

next. In the interim, institutions had stopped equipping themselves with computerized management tools.

As a result, then, of promises that had not been kept, waiting lists for disciplines other than tertiary cardiology were left without any kind of management system.

A number of obstacles and challenges marked the development and implementation of SGAS, most particularly because of internal problems at the MHSS and obstacles that came up during negotiations with the doctors and the institutions in play.

With respect to the internal problems at the MHSS, a lack of commitment and of continuity had resulted in organizational problems at the ministry. For example, waiting lists in tertiary cardiology might be one responsibility, the lists in radio-oncology a second and computerization a third. In addition, SOGIQUE, the private firm in charge of developing the computer program, had its own role to play. This dissipation of responsibilities put the very viability of the project at risk. The succession of directors and of ministers was additional obstacles to the continuity of the project as some actors were less convinced of the merit of deploying the SGAS system. The differing management styles of the participants further hampered progress. For example, the instinctive political reaction of Jean Rochon was to obfuscate information on waiting lists, while Pauline Marois was more open to disseminating information. It was therefore necessary that the MHSS continually readapt to different styles. The organizational culture of the ministry thus played an important role in the evolution of the dossier.

Another striking aspect of the management of this portfolio was the absence of anyone to carry the project at the political level. Indeed, no individual surfaced as able to carry the project at the strategic level within the MHSS. No single person concerned had enough influence with deputy ministers and the minister him/herself to ensure the timely progress of the portfolio. From the beginning, SGAS was seen as a technical dossier only relevant to specialists. The lack of leadership and strategic vision, then, led to an absence of economic forecasting, jeopardizing the development of the system for other types of surgeries.

management of waiting lists (treatment quality control, monitoring of the priority for surgeries ð the system itself decided on the priority for surgery). They found it difficult to accept the idea of SGAS as a tool in the service of medical practiceé

In the end, in order to bring the doctors on board, the MHSS decided to finance the purchase of technology for doctors who would agree to participate in the project. After this move, the next challenge was to bring everyone together to discuss the next step. It took enormous amounts of time and energy to succeed in uniting heart surgeons, the cardiologists of Quebec and Montreal and the referring cardiologists of other regions in order that they reach an agreement on clinically acceptable wait times, the content of the SGAS tool and how to coordinate case treatment. Consensus was extremely difficult to reach.

With respect to the day-to-day management of SGAS, doctors did not wish to personally take on data collection for the system, as this would increase their workload. The SGAS system, however, is based on the progressive compilation of data by all individuals participating in the treatment of a patient awaiting surgery. Paradoxically, even if doctors resisted personal participation in the data collection process, they also opposed the idea of incremental compilation. Because SGAS was designed to permit the evaluation of the quality of treatment and services, doctors did not wish to relinquish control of data collection out of fear that this might compromise the reliability of the data in question.

In closing, it is clear that the development and implementation of SGAS was the fruit of the labours of a small number of actors. The project was managed behind closers 30-3(behind cl)-1.jes HSw2(After) esisSf the rrce(rs)-2(w)3(hinvv

- The Quebec Hospital Association;
- Participating institutions;
- Nurses.

extremely difficult to reach. For the public, the difference between 4 and 8 weeks was crucial.

3.3 How SGAS works in radio-oncology

The SGAS system is somewhat different in radio-oncology than in tertiary cardiology. Because the machinery with which radiation therapy treatments are administered are all equipped with a computerized system for planning patient appointments, SGAS-Radiation-Oncology merely manages the patient list according to the level of priority of each case.

4. The other waiting lists

As of 1995, the MHSS introduced a manual system for the collection of data on waiting lists for all other surgeries. Forms were sent to each institution, which in turn transmitted the information to the Regional Boards and then the MHSS. Data was compiled manually every three months. It was then necessary to enter the data by hand into a central file at the MHSS. This means of proceeding did not permit for a reciprocal return of information back to the institutions. Since then, the

respective lists. The problem is to incorporate all of these individual lists into a single system.

5. Other measures (apart from SGAS) taken to address the issue of waiting lists

Other measures were undertaken at the same time as SGAS in order to cut back on waiting times:

- Measures in personnel planning;
- Increase in student cohorts;
- Inter-hospital transfer programs;
- Measures providing for supplementary work hours for some professionals (especially technical specialists);
- The purchase of equipment;
- Measures aiming for the prevention of illness and the promotion of health.

THIRD SUB-PERIOD: 2003-THE PRESENT – SEQUELS OF SGAS

1. The election of 2003

The electoral platform of the Liberal Party brought the problem of waiting lists back to the forefront of public awareness. It was one of the key issues of the party's program. So the election of a Liberal government and the advent of Philippe Couillard began a new period in the dossier of waiting lists.

1.1 The volume of operations

With the advent of Philippe Couillard, certain surgical procedures were targeted for action (cardiovascular care, orthopedic care and opththalmological care – cataracts in particular). It was hoped to reduce waiting lists in these specialties by performing a greater number of operations. Extra funds were consequently disbursed according to the demand for operations. Targeted procedures were undertaken in order to sporadically address the problem. Accordingly, it became possible to monitor the volume of operations somewhat more precisely, as a consequence of targeted investments. It was at this point that the project to keep the public up-to-date on waiting lists by means of the Internet first appeared.

1.2 Waiting lists on the World Wide Web

During the electoral campaign, the Liberals had promised to make waiting lists available on the Internet. The Liberal platform spoke of giving patients the opportunity to choose (that is, to shop for) the hospital where they

V Analysis of the reform process

Analysis of the reform process during the implementation of SGAS testifies to a difficult and chaotic experience. Ideas advanced slowly and the dossier was subject to much experimentation before SGAS was finally put in place. Even after this happened, the SGAS project suffered from a lack of leadership, of continuity, and of funding. We will now proceed to a more precise analysis of the various elements that made the project so complex and difficult to implement.

1. Institutional factors

Provincial-level administration is responsible for the management and monitoring of waiting lists. It is true that the federal government can intervene in the matter by means of targeted investments. (LA-02 WLQC): in the case of SGAS, however, decisions were made at the provincial level. The principal institutions involved were the MHSS, the Regional Boards and the various health care institutions. (LA-05 WLQC). At the ministerial level, the entities involved in the project when it was piloted were dispersed in 3 directions, without counting the different ministries involved: these did not necessarily share the same vision for waiting list management (LA-06 WLQC). Furthermore, the SGAS dossier was never seen as a political dossier but as a technical one, and it never benefited from strong leadership at the political level (LA-02 + LA-06 WLQC): the principal leaders of the project were ministry employees. From the start, the Ministry of Health perceived the problem of waiting lists as a technical issue with little political relevance. The ministry had been monopolized by the problem of emergency room care and it therefore applied to the problem of waiting lists, the same method that had been used for the problem of emergency rooms: the creation of a support group for access to surgical care. The group was not, however, provided with the financial means of addressing the crisis. In fact, the very title of the group testifies to the fact that the main issue for the ministry was access and not waiting lists. The Treasury Board had no role in the funding of SGAS (LA-03 WLQC).

Turning to the policies around waiting lists, it is apparent that SGAS is a by-product of the Rochon reforms introduced in the 1990's. In fact, budget restraints (the zero deficit, early retirement programsé) and the shift towards ambulatory care (hospital closures and decreases in the number of

hospital beds) were the two driving forces behind the inflation of waiting lists in Quebec (LA-05 WLQC). As of 1995, strong media pressure publicizing cases of victims of serious illness awaiting treatment, forced the government to face the problem and take action on the issue (LA-05 WLQC).

Prior to SGAS, there was no central means of monitoring waiting lists. Because of this, the government lacked a broad-based understanding of the problem and had to submit to the pressure of the press without any means of defence (LA-02 WLQC). As a means of responding to the pressure, the government would sporadically inject funds into the system in an attempt to the problem, but it did so on a reactive level, and not as part of a deliberate plan.

Local-level health care institutions put their own waiting list monitoring systems in place, but these systems were not common to all institutions and were most often òhome madeó (LA-06 WLQC) if not òhand-madeó (LA-05 WLQC). For that reason, it was impossible to compare data between institutions and to have an idea of what was happening at the provincial level (LA-05 WLQC): all the more so, given that the very definition of waiting lists differed from one institutions to the next.

Finally, the recent landmark ruling of the Supreme Court in the òChaulió affair testifies to the importance of this issue for Quebec as well as for Canada. Access to care has clearly become a major concern for Canadians, one that will have enormous influence on the evolution of the Canadian health care system.

The press played the principal role in putting the issue on the governmental agenda. Almost every night on the news, reporters profiled the case of a wait-listed person at risk of death as a result of the delay in treatment. The media pounding was nothing less than intense (LA-05 WLQC). In this way, the public used the media as a vehicle to voice its concern and bring about a decrease in waiting times (LA-05 WLQC).

Numerous studies on the problem of waiting lists, written in the form of research and articles, most particularly in countries with state financing, began to appear in the 1970ís and grew in number in the 1990ís. Most addressed the problem in liberal welfare states (the Beveridge system).

It was only relatively later, in 1998, that a certain consensus was finally reached among decision-makers, professionals and consumer interest groups, with respect to the implementation of a management system for waiting lists. In the background, however, continued to lurk strong reticence on the part of the medical profession and health institutions.

It can be said, then, that the problem of waiting lists was managed principally as a question of technology, and that the hypothesis behind the policy decisions was that the Rochon reforms, particularly decentralization of services and the shift towards ambulatory care, would change the structure of the health care system, thereby fixing the problem of access; a technological tool would give decision-makers a better command of the situation.

2. Interest group factors

Patients and the general population put the media very much to use in order to publicize the extent of problems related to the waiting lists (some individuals died not having had access to care, especially surgical care) (LA-06 WLQC).

The publication of the findings of studies on the management of waiting lists in other Canadian provinces also clearly influenced the policy in Quebec (LA-02 + LA-05 WLQC). The principal source of inspiration was the of Ontario (LA-03 WLQC). This was followed by the experience of Saskatchewan and the (LA-05 WLQC). Certain hospital experiences also helped in the construction of SGAS (LA-06 WLQC). Furthermore, the Regional Board of Montreal foresaw the need to put a management tool for waiting lists in place and had accordingly installed its own system as of 1998. This system was oriented towards the management of waiting lists for heart surgery, hip replacements, knee replacements and cataract surgery, and it allowed administrators to follow the evolution of these lists over time. The system had been inspired in large part by the work of the NHS in the United Kingdom (LA-02 WLQC). It was abandoned, however, once the SGAS project was launched (LA-02 WLQC).

Ever since the beginning of the 1990ís, the ministries of health, for their part, had been confronted with the problem of waiting lists; a problem

reliable data, data that would permit a better understanding of the nature of waiting lists and would allow for the quantification of waiting times.

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enough to give the public a reasonably accurate notion of how long they could expect to wait (LA-02 + LA-03 + LA-05 WLQC).

4. External factors

Numerous reports, committees, plans, and tools were published, formed and developed during the 1990ïs on the subject of waiting lists.

- The report of the Committee for General and Orthopedic Surgery (1993)
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(1994)

- The Action Plan for Access to Surgical Care (1995) (Jean Rochon)

A Management Guide for the Operating Room

The Support Group for Access to Surgical Care

The Classification of Patients Awaiting Heart Surgery

The Final Report of the Working Group on Tertiary Cardiology

The SGAS Organization Manual

- The position paper of the College of Physicians (2003)

At a political level, several health ministers succeeded each other during the 1990ïs. An important transition in the management of the dossier took place between the ministries of Jean Rochon and Pauline Marois, who did not share the same vision of theSo8 an

The economic pressures of the 1990's and the separatist government's commitment to a zero deficit are largely responsible for the appearance of waiting lists in Quebec. The draconian budget cuts made to the health care system and the shift towards ambulatory care were two key factors in the phenomenon. Waiting lists thus became a short-term means of managing the system (LA-02 WLQC).

None of those interviewed and no reports suggested that technological change or the appearance of new diseases might have had an impact on the question.

In contrast, the press played a major if not crucial role in the management of waiting lists by its constant hammering of the same message over a period of years: people were dying from a lack of access to care. The influence of the media forced the government to put the issue on its agenda (LA-05 WLQC).

In closing, research in other provinces had a strong influence on the policy, even though those interviewed did not imply that an access management model was imported from elsewhere (LA-06 WLQC) or that alternative models to the SGAS had been considered.

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