

TIME FOR TRANSFORMATION

Canadians still waiting too long for health care

Report Card on Wait Times in Canada

June 2013

Overview

Despite many good intentions and efforts, Canadians are still waiting too long to access health care. In many regions, medical specialties and practices, no substantial or sustained progress in reducing waits has been achieved in recent years. Structural change in the Canadian health care system is long overdue if this stagnation is to be overcome.

The 2013 report card of the Wait Time Alliance (WTA) contains three sections:

1. Grading Canadians' timely access to care:

Performance for the five initial areas has been graded against the pan-Canadian government benchmarks, and performance for a wider range of procedures and treatments has been graded against WTA benchmarks. As was the case last year, the percentage of patients receiving care within benchmark wait times for the initial procedures for which pan-Canadian government benchmarks exist (i.e., radiation therapy, cardiac bypass surgery, hip and knee replacement, and cataract surgery*) has not increased. Although some provinces have shown improvement, the national results for 2013 show few signs of progress, which means continued lengthy waits for many Canadians. The lack of progress on wait times also applies to numerous other procedures for which the WTA has its own

benchmarks. Some reporting exists for procedures in obstetrics and gynecology and plastic surgery, but there remains no provincial reporting for such specialties as anesthesiology (specifically treatment of chronic pain) gastroenterology (except for Nova Scotia) and psychiatry. This year's report card also highlights the impact of socio-economic status on wait times.

2. Grading provincial wait-time websites: As is the case for wait-time grades, the quality of provincial wait-time websites is highly variable. Some provincial websites continue to improve, but the functionality of others has improved little over the past four years.

3. Making structural changes to sustain decreases in wait times: Reductions in wait times have plateaued in many jurisdictions; that is, provinces do not seem able to achieve significant further reductions in the length of time that Canadians wait to access necessary medical care, beyond what has been achieved to date, despite additional funding. As such, the WTA believes that additional funding cannot be the sole solution. Rather, the best way to make sustained reductions in wait times is to implement structural changes in how wait times are mitigated, measured, monitored and managed (an approach that was first introduced by the WTA as the 4-M Toolbox of strategies¹). Examples of structural changes are provided.

*Diagnostic imaging (specifically magnetic resonance imaging and computed tomography) was the fifth initial priority area. However, no pan-Canadian government benchmarks have yet been established in this area.

Time for structural change

It has been almost 10 years since the 2004 Health Accord was signed by Canada's First Ministers. A major element of that agreement was a commitment by governments to address the lengthy wait times that Canadians face when they seek medical care. The WTA has been tracking provincial government performance on wait times since 2007 through its annual report cards. Our 2013 report raises a number of concerns, particularly the continued backsliding with respect to the percentage of patients treated within government-approved wait-time benchmarks. As the Canadian Institute for Health Information (CIHI) recently reported, although an increasing number of surgeries are being performed in the areas targeted in the 2004 accord, wait times are not improving. It would appear that "demand is rising at a rate that is outpacing the ability of health systems to keep up."²

As detailed in this report, there have been some improvements in recent years, but the collective goal to improve Canadians' timely access to care has not yet been attained. Canadians still wait too long to access many health care services. Moreover, Canadians wait longer for care than citizens of most other industrialized countries with publicly financed systems. For example, the average wait time for hip and knee replacements in the Netherlands is eight weeks, and the average wait time for cataract surgery is five weeks,³ yet many Canadians wait longer than 26 weeks for a hip or knee replacement and more than 16 weeks for cataract surgery. Both Scotland and England have set and met the target of having 90% of elective care patients wait no longer than 18 weeks from general practitioner referral to start of treatment for a wide range of medical care. This 18-week period includes the wait period before seeing a specialist and the wait for any diagnostic tests.

The Organisation for Economic Co-operation and Development (OECD) recently reviewed the strategies that other industrialized countries with lengthy wait times have implemented to ensure timely access to care for their citizens. The resulting report — *Waiting Time Policies in the Health Sector: What Works?* — has lessons to offer Canada with regard to the effectiveness of wait-time reduction strategies.³ The findings presented by the OECD demonstrate that the common approach of temporarily increasing funding to augment the supply of services has only a temporary effect on wait times. Often, wait times lengthen again following an initial decrease, since the short-term funding does

not involve any structural changes to the ways in which services are delivered. This finding is timely, given that it is unlikely any additional funding to address wait times will be forthcoming from provincial governments in the near future.

The OECD has concluded that countries that have implemented structural changes are more likely to succeed in reducing wait times on a sustained basis. Structural changes implemented at the national level have included adopting activity-based budgeting for hospitals (rather than applying global budgeting, as is done in Canada), adopting wait-time guarantees that are enforced and that provide greater choice for patients who wish to find alternative providers with shorter wait times (often through integrated information systems) and using clinical prioritization and appropriateness tools to assess and prioritize patient need. The Netherlands, Denmark, Portugal and the United Kingdom are just some of the countries that have implemented these types of structural reforms (see Box 1). Different tools may be required for countries with different circumstances.

It is time to adopt structural or transformative changes — both at the health system level and at the front-line level — if Canada is to have any hope of achieving and sustaining success in reducing wait times. As CIHI noted in its 2013 report,² redirection of resources is most likely to be effective if it is accompanied by changes in the way procedures are managed.

Encouragingly, some structural changes to address wait times are under way in most provinces, and several of these are highlighted throughout this report. However, more such changes are required to create sustained reductions in wait times and to improve quality of care for Canadians. Such efforts should include:

- Addressing the needs of elderly patients and patients needing alternate levels of care (ALC), who are often waiting for more appropriate levels of care.
- Addressing the needs of patients who are frequent users of the system but who often need low-technology solutions.
- Reorganizing how hospitals are funded (e.g., through partial activity-based funding) so that they have an incentive to provide more services but also to provide such services as efficiently as possible. This approach would also support the use of effective patient wait-time guarantees that have consequences, unlike the existing wait-time guarantees in Canada, which have minimal impact on wait times.

- Increasing efforts to ensure that appropriate care is provided (e.g., through the use of appropriateness guidelines).
- Improving Canadians' access to affordable prescription drugs.
- Identifying common goals among health care system stakeholders, including patients, providers and governments.
- Developing patient-centred models of care from the ground up.
- Putting greater effort into collecting, monitoring and managing standardized wait-time data on the full range of health care services provided.
- Engaging patients in all of the strategies listed above.

Box 1: Structural reforms implemented in other countries to reduce wait times*

England and Scotland

Referral to treatment wait guarantee: A maximum 18 weeks from referral by a general practitioner to start of specialty treatment for elective conditions, including specialist consultations and diagnostic testing is guaranteed. This guarantee is enshrined in the English National Health Service Constitution.⁴

The guarantee is monitored by the Department of Health, with a target of 90% of admitted patients and 95% of outpatients to be treated within the 18-week limit. Any breach of these targets will result in a reduction of up to 5% of revenue for the relevant specialty in the month in which the breach occurs.

Portugal

Integrated Management System of the Waiting List for Surgery (SIGIC): A centralized electronic platform that facilitates movement of patients across the country for faster access to care. When a patient who is waiting for care reaches 75% of the maximum wait time, he or she receives a voucher that allows transfer to another hospital (public or private). Because funding follows the patient, the initial hospital has an incentive to ensure the patient is treated before the wait reaches 75% of the maximum. SIGIC also provides clinical information about the patient and monitors system performance. The median wait time for surgery declined by almost 63% from 2005 to 2010 upon implementation of the SIGIC, even though the demand for surgery increased.

The Netherlands

Activity-based funding system for hospitals and specialists.

Waiting-list mediation services: The Netherlands' publicly funded health system is administered by private health insurance companies. These companies actively search, on behalf of patients, for hospitals with shorter wait times. Patients are free to choose whether to use the alternatives identified by the mediation service.

Denmark

Partial system of activity-based funding for hospitals (50% of total budgets).

One-month wait-time guarantee for non-life-threatening conditions. Wait-time guarantees of shorter duration have been set for all types of cancer.

Strong public reporting of wait times via a government health portal with search functions.

*Source: Siciliani et al.³

1. Grading Canadians' timely access to care

The 2007 and 2008 WTA report cards focused solely on provincial performance with respect to the procedures identified in the 2004 Health Accord: cancer care (specifically radiation therapy), cardiac care (specifically coronary artery bypass graft [CABG] surgery), joint replacement (hip and knee), sight restoration (specifically cataract surgery) and diagnostic imaging (computed tomography [CT] and magnetic resonance imaging [MRI]), although benchmarks for diagnostic imaging were not established by governments at the time of the original accord. Since then, the WTA has directed its attention toward the following goals: (1) broadening the scope of its report to include Canadians' access to all areas of care, (2) highlighting areas where the quality of public reporting on timely access can and should be improved, (3) highlighting issues that contribute to lengthy wait times and (4) identifying best practices to reduce wait times.

Based on provincially reported data, Table 1 presents letter grades to indicate how well each province is performing in terms of the percentage of patients receiving treatment within the benchmark time for each procedure of interest. New for the 2013 report card is the assignment of a grade of A+ for instances where 90% or more of patients were treated within the benchmark time. The colour grades indicate whether the percentage of patients treated within the benchmark has changed between spring 2012 and spring 2013: green indicates an increase of 5% or more in the proportion of patients treated within the benchmark relative to the previous year, red indicates a decrease of 10% or more in the proportion of patients treated within the benchmark, and yellow indicates no substantive change between these two periods.

A. Grading performance using pan-Canadian benchmarks set by provincial governments

The top portion of Table 1 presents letter grades for these procedures using the pan-Canadian benchmarks set by provincial governments. The results for 2013 can be summarized as follows:

- There was no improvement in the overall national letter grades between 2012 and 2013 in terms of the percentage of patients treated within the government-set benchmarks. More specifically, the proportion of A and A+ grades in both years was 58%. Canadian patients waiting for knee replacement continue to face the longest waits,

with a national grade of C and two provincial grades of F (Nova Scotia and PEI).

- There was slight year-over-year improvement, as indicated by the shift in colour grades from 2012 to 2013. More specifically, the proportion of green squares, indicating increases of 5% or more in the proportion of patients treated within benchmark times, rose from 22% in 2012 to 29% in 2013. However, these proportions pale in comparison with the 2011 result, which featured 45% green squares (Table 2):

Table 2: Comparison of grades, 2011–2013

Indicator	2011 report card	2012 report card	2013 report card
Sum of A and A+ grades as proportion of all grades	56%	58%	58%
No. of F grades	1	2	2
Proportion of green squares*	45%	22%	29%
Proportion of red squares†	4%	16%	13%
Proportion of yellow squares‡	51%	62%	59%
*Green squares in Table 1 denote increases of 5% or more in the proportion of patients treated within the benchmark relative to the previous year. †Red squares in Table 1 denote decreases of 10% or more in the proportion of patients treated within the benchmark relative to the previous year. ‡Yellow squares in Table 1 denote no substantive changes relative to the previous year.			

The pursuit of more timely access to care is a journey that will see its share of setbacks. However, the WTA is concerned about this second consecutive year without any substantial progress on reducing wait times in several provinces, particularly given that the government benchmarks still represent long waits. This year's assessment clearly demonstrates the need for structural change to sustain improvements in Canadians' access to timely care.

B. Grading a wider range of procedures, treatments and diagnoses using WTA benchmarks

Since 2007, the WTA has called on governments to endorse national wait-time benchmarks or targets for health services

beyond the initial five areas. In fact, the 2004 Health Accord stated that governments were to “start” with the initial five areas, not to begin and end with them. Recognizing the importance of reducing waits for all patients, the 14 members of the WTA have established wait-time benchmarks for a total of 925 treatments, procedures and diagnoses (complete list available at www.waittimealliance.ca/wait_times.htm).

The bottom portion of Table 1 lists 45 procedures, treatments and diagnoses that have the highest volumes, the greatest potential for improvement or the greatest potential return on investment, according to input from WTA members. For this section of Table 1, waits were graded on the basis of information publicly available on provincial websites. A question mark appears if the province does not report wait times for the particular procedure, treatment or diagnosis. An eyeglasses symbol (Ⓔ) indicates that the province tracks wait times for the pertinent specialty but not for the specific procedure in a manner that would permit grading by WTA measures. This section of the table includes grades for some of the procedures with provincial government benchmarks (specifically CABG, radiation therapy and diagnostic imaging), but here the grades are based on WTA benchmarks, which are significantly different from the pan-Canadian benchmarks. Importantly, the WTA views any reporting as positive, even if the resulting grade is low or the procedure is assigned an eyeglasses symbol. As such, a low grade or the eyeglasses symbol indicates a more favourable situation than complete lack of reporting (indicated with a question mark).

It should be noted that the WTA benchmark for non-urgent diagnostic imaging has been revised and is now a maximum of 60 calendar days (see Section 3 for further details).

Just over 20% of the procedures listed in the bottom section of Table 1 could be graded using the WTA benchmarks, with Ontario and Nova Scotia reporting the most procedures for grading. However, the overall number of procedures reported in 2013 represents a slight increase from 2012. Although many of the grades attained with the WTA benchmarks were low, there was a slight increase in year-to-year improvement (i.e., an increase in proportion of green squares) from 2012. The grades for cancer care and cardiac care were lower with the shorter WTA benchmarks than with the government benchmarks used for the top portion of Table 1. For example, although all provinces providing CABG received an A grade in relation to the government benchmark of 26 weeks, grades were lower in relation to the WTA benchmark of six weeks.

Still, there remains a lack of progress on any provincial reporting for such specialties as anesthesiology (management of chronic pain), gastroenterology, emergency care (with only Ontario and Alberta reporting on emergency department [ED] wait times) and psychiatry. The WTA believes it is important for Canadians to have timely access to the full range of medical care, as well as to information about performance of these components of the health care system.

Table 1: Wait-time grades based on government and WTA benchmarks

Treatment/service/procedure		NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	National grade†
Five initial areas: Grading using government benchmarks												
Diagnostic imaging – MRI	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb
Diagnostic imaging – CT	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb
Joint replacement – Hip	26 weeks	A+	B	D	B	B	A	D	C	B	A	B
Joint replacement – Knee	26 weeks	A	F	F	C	B	A	D	D	B	B	C
Radiation therapy [Ⓜ]	4 weeks	A+	A+	A	A+	A+	A+	A+	A+	A+	A+	A+
Cataract surgery	16 weeks	A+	C	C	A	A	A	C	C	B	A	B
Heart – coronary artery bypass graft (CABG)▼	26 weeks	A+	na	/	A+	A+	na	A+	A+	A+	A+	A+
WTA selected procedures: Grading using WTA benchmarks												
Anesthesiology (chronic pain) ☀												
Nerve damage after surgery or trauma	30 days	?	?	?	?	?	?	?	?	?	?	?
Pain related to disc problems	3 months	?	?	?	?	?	?	?	?	?	?	?
Cancer pain	2 weeks	?	?	?	?	?	?	?	?	?	?	?
Exacerbations or flare-ups of chronic pain	3 months	?	?	?	?	?	?	?	?	?	?	?
Cancer care (radiation therapy, curative care)												
All body sites combined	14 days	?	C	D	?	?	A+	B	A	A	A	?
Breast	14 days	?	?	D	?	?	A+	D	?	?	?	?
Prostate	14 days	?	?	D	?	?	A	F	?	?	?	?
Lung	14 days	?	?	B	?	?	A+	B	?	?	?	?
Cardiac care (scheduled cases) ☀ ☀ ☀ ☀ ☀ ☀												
Electrophysiology catheter ablation	90 days	?	na	/	?	?	?	?	?	?	?	?
Cardiac rehabilitation	30 days	?	?	?	?	?	?	?	?	?	?	?
Echocardiography	30 days	?	?	?	?	?	?	?	?	?	?	?
CABG▼	6 weeks	B	na	/	A+	B	na	A	?	F**	B	?
Diagnostic imaging (non-urgent)												
MRI	60 days	?	F	D	?	?	A	?	?	F	?	?
CT	60 days	?	A	A	?	?	A	?	?	A	?	?
Emergency department (Length of stay wait-time benchmarks)												
Non-admitted patients: CTAS level 1 (resuscitation)	8 hours	?	?	?	?	?	A	?	?	A (based on 4-hour target for all non-admitted patients)		?
CTAS level 2 (emergent)	8 hours	?	?	?	?	?	A+	?	?			?
CTAS level 3 (urgent)	6 hours	?	?	?	?	?	A	?	?			?
CTAS level 4 (less urgent)	4 hours	?	?	?	?	?	A	?	?			?
CTAS level 5 (non-urgent)	4 hours	?	?	?	?	?	A	?	?			?
Admitted patients: CTAS level 1 (resuscitation)	8 hours	?	?	?	?	?	D	?	?	D (based on 8-hour target for all admitted patients)		?
CTAS level 2 (emergent)	8 hours	?	?	?	?	?	F	?	?			?
CTAS level 3 (urgent)	6 hours	?	?	?	?	?	F	?	?			?
CTAS level 4 (less urgent)	4 hours	?	?	?	?	?	F	?	?			?
CTAS level 5 (non-urgent)	4 hours	?	?	?	?	?	F	?	?			?
Gastroenterology												
Cancer	2 weeks	?	?	?	?	?	?	?	?	?	?	?
Inflammatory bowel disease (IBD)	2 weeks	?	?	?	?	?	?	?	?	?	?	?
Fecal occult blood test positive	2 months	?	?	?	?	?	?	?	?	?	?	?
Joint replacement (Orthopedics) ☀ ☀ ☀ ☀ ☀ ☀												
Total hip arthroplasty	26 weeks	A+	B	D	B	B	A	D	C	B	A	?
Total knee arthroplasty	26 weeks	A	F	F	C	B	A	D	D	B	B	?
Nuclear medicine (scheduled cases) ☀												
Bone scan – whole body	30 days	?	?	?	?	?	?	?	?	?	?	?
FDG-PET	30 days	?	?	?	?	?	?	?	?	?	?	?
Cardiac nuclear imaging	14 days	?	?	?	?	?	?	?	?	?	?	?
Obstetrics and gynecology (scheduled cases) ☀ ☀												
Abnormal premenopausal uterine bleeding	12 weeks	?	?	B	?	?	?	?	A	?	?	?
Urinary incontinence	12 weeks	?	?	D	B	?	C	?	D	?	?	?
Pelvic prolapse	12 weeks	?	?	F	?	?	D	?	D	?	?	?

Treatment/service/procedure		NL	PE	NS	NB	QC	ON	MB	SK	AB	BC
Plastic surgery											
Breast cancer reconstruction	4 weeks	?	?	?	?	?	F	?	?	?	?
Carpal tunnel release	2 months	?	?	C	B	?	?	?	B	F	?
Skin cancer treatment	4 months	?	?	?	?	?	?	?	?	?	?
Pediatric surgery*											
Advanced dental caries: carious lesions/pain	90 days	?	?	?	?	?	?	?	?	?	?
Cleft lip/palate	21 days	?	?	A+	?	?	?	?	?	?	?
Strabismus: 2–6 years old	90 days	?	?	?	?	?	?	?	?	?	?
Psychiatry (scheduled)											
Early psychosis	2 weeks	?	?	?	?	?	?	?	?	?	?
Postpartum severe mood disorders	4 weeks	?	?	?	?	?	?	?	?	?	?
Acute/urgent mental health concerns	1 week	?	?	?	?	?	?	?	?	?	?
Sight restoration											
Cataract surgery	16 weeks	A+	C	C	A	A	A	C	C	B	A

Methodology

Based on data published on provincial websites in April and May 2013:

A+: 90%–100% of population treated within benchmark

A: 80%–89% of population treated within benchmark

B: 70%–79% of population treated within benchmark

C: 60%–69% of population treated within benchmark

D: 50%–59% of population treated within benchmark

F: Less than 50% of population treated within benchmark

na: No data provided or data do not lend themselves to estimates of performance. A diagonal line (/) in white squares indicates that the service is not provided (e.g., CABG in PEI).

nb: No benchmarks. Pan-Canadian benchmarks for diagnostic imaging have not yet been established by governments. Where provinces have reported wait times for diagnostic imaging, a colour grade is assigned to note progress made over the last 12 months.

† National grades are based on a weighted average of provincial letter grades.

♥ The category for bypass surgery (CABG) represents only a small part of the full continuum of cardiac care provided to patients. Please refer to the Canadian Cardiovascular Society website at www.ccs.ca for a full range of benchmarks for cardiovascular services and procedures. All of these benchmarks will have to be adopted to meaningfully address wait times.

⊕ Cancer radiotherapy. Wait times currently reflect only waits for external-beam radiotherapy, whereas waits for brachytherapy (implanted radiation treatment, e.g., for prostate and cervical cancers) go unreported.

⊘ Province does not report wait times for the treatment.

⊘ Province reports wait times for this specialty but not for the specific procedure in a manner that would permit it to be graded by WTA measures.

⊘ Province reports on procedures or wait times for this specialty.

* These benchmarks enable pediatric institutions to compare with peers and to share learning.

** Alberta calculates CABG wait times from the date of cardiac catheterization or from the date of alternate imaging to the date of surgery. If no imaging is performed, the wait time begins at referral to surgery. This method can lead to a longer recorded wait time than would be recorded if referral to surgery were used as the starting point.

Colour grading methodology

This table identifies changes in wait times using the most recent publicly available data for each of the five priorities by province as follows:

	↓ decrease in wait times over the previous year
	↑ increase in wait times over the previous year
	↔ no significant change (i.e., less than 5% increase or less than 10% decrease) over the previous year
	⊘ insufficient data to make determination

C. Assessing and improving Canadians' total wait time to access care

The WTA's 2012 report focused on the need to improve measurement and reporting of Canadians' total wait time to access care. Most of Canada's efforts to date have aimed to shorten the wait between the decision to treat (which is made jointly by the specialist and the patient) and the start of treatment (Figure 1). Yet this is only one portion of the total wait time faced by patients. Moreover, as shown in the WTA's 2012 report card, patients often wait longer to see the specialist than they wait to start treatment.⁵ There can also be a wait to access diagnostic imaging (e.g., MRI or CT). Furthermore, some Canadians may have to wait to see a family physician, whereas others do not even have a family physician.

Currently, little is known about how long Canadians wait to be seen by a consulting specialist. As reported last year, a few provinces have taken steps to capture and report data on this portion of the patient's wait. For example, Saskatchewan reports on the first appointment with the specialist for many procedures. Data are not available for all specialists in that province, but this reporting is a strong start toward reporting on wait times for specialist referrals. Nova Scotia reports wait times to see specialists from any of 14 defined specialties in the Capital Health Region.

The Canadian Medical Association (CMA), in conjunc-

tion with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada, has developed a toolbox to improve referral and consultation wait times (see Section 3 for further details).

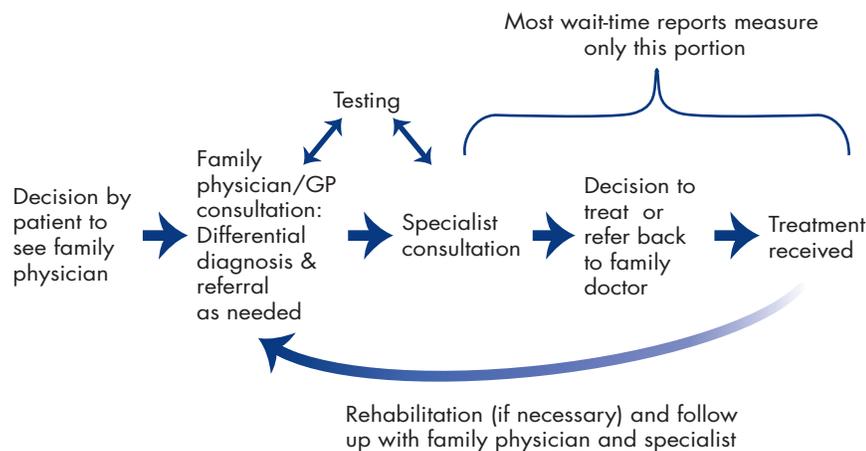
D. Determining the impact of socio-economic status on wait times

Last year's report identified differences in wait times within provinces, whereby residents living in some regions of a given province had shorter wait times than those in other regions. WTA members recognize that many factors contribute to lengthy wait times. In particular, as we discussed in our 2011 and 2012 reports, system-level factors, such as ALC stays, can influence wait times.

In this section, we briefly discuss factors outside of the health system that can contribute to wait times. In particular, a suite of factors known as the social determinants of health (including income, education, housing and gender) can influence the health of the population and determine who has access to the health care system and in what manner. For instance, a person's gender or age can lead to specific health needs and a specific patient journey requiring certain health responses (e.g., undertaking a gender analysis to detect the impact of service delivery on access).⁷

Most major diseases, including heart disease and men-

Figure 1: Wait times from the patient's perspective



Adapted from prototype shared by The College of Family Physicians of Canada and from ICES, *Access to Health Services in Ontario, Fig. 1.1*

tal illness, follow a social gradient, with those in the lowest socio-economic groups having the greatest burden of illness.⁸ Correspondingly, utilization of health services follows a reverse socio-economic gradient, with those in the lowest socio-economic brackets using far more health services than those with higher socio-economic status. Does the correlation between socio-economic status and health system utilization have an impact on timely access for the overall population? In previous studies, people with lower socio-economic status were much more likely to be admitted to hospital for ambulatory care sensitive conditions (ACSC) and mental health concerns, admissions that could potentially be avoided with appropriate primary care and which have trickle-down effects on total system capacity.^{9,10} These patients were also found, on average, to have longer lengths of stay.¹¹ Patients considered as needing ALC were more likely to have a low-income profile.¹² Furthermore, people with ACSC in low-income groups, those living in rural areas and those with multiple chronic conditions were twice as likely to report using ED services for care that could have been provided by a primary care provider.¹³

Many of these patients are required to use these often-unnecessary services because of barriers to accessing primary care, as well as barriers to accessing non-insured services. For example, individuals from low-income neighbourhoods were more likely to report difficulties making appointments with their family doctors for urgent, non-emergent health problems. They were also more likely to report unmet health care needs.¹⁴ There is a gender element to this situation as well, in that Canadian women are more likely than men to live in poverty.¹⁵ Researchers have reported that those in the lowest income groups are three times less likely to fill prescriptions and 60% less able to get needed tests because of cost.¹⁶

Increasingly, strategies are being developed to better match services with the health needs of these patients. Hospitals working with the Institute for Healthcare Improvement in the United States have developed a four-step process for high health system users. They first identify the patient group of interest by examining measures like ED visits and hospital admissions. Once the group has been identified, the hospitals assess the various root causes of the high use.

From there, they develop programs for a small number of users and then scale the programs up to serve the full complement of high-cost users.

In Ontario, the Health Links program aims to increase coordination and thereby reduce the inappropriate use of services by those considered to be high health system users. One of the pilot sites (in Guelph) aims to assign one primary care provider, likely a doctor or a nurse, to be the main contact for patients deemed to have high needs and to intervene on behalf of these patients to ensure better care coordination.¹⁷

Although reducing the health burden related to socio-economic conditions is outside of the WTA's purview, we emphasize that efforts to increase access and proper utilization of health services will help to reduce wait times for all Canadians.

2. Grading provincial wait-time websites

The ideal provincial wait-time website should make it easy for patients, family members and health care providers to determine wait times in their area in a timely fashion using reliable data. For the fourth consecutive year, the WTA has rated provincial wait-time websites (as of May 2013) using the following five criteria:*

1. **Timeliness:** How recent are the reported wait times, both in terms of recentness of the data reported and frequency of updating?
2. **Comprehensiveness:** How comprehensive is the range of procedures and treatments reported?
3. **Patient-friendliness/accessibility:** Is the information on wait times easy to find and use for patients and other members of the public and for their health care providers?
4. **Performance orientation:** Is it easy to determine the length of the wait and whether it meets the benchmark or target?
5. **Quality/reliability:** Do reported wait times reflect actual wait times?

The WTA asked three patient groups to help in grading the third criterion—patient-friendliness/accessibility—in an effort to incorporate patients' voices in this year's review process.†

*A full explanation of the website ratings can be found in the WTA's technical backgrounder for the 2013 report card found at www.waittimealliance.ca.

†The WTA wishes to thank the three patient representative groups that participated in grading the patient-friendliness of the websites: Alliance des communautés culturelles pour l'égalité dans la santé et les services sociaux, the Canadian AIDS Society and the Brain Injury Association of Canada.

2013 Results

Table 3 provides the results of the 2013 grading of provincial wait-time websites. Notable improvements over the previous year include the listing of wait times by hospital in Quebec and fur-

ther enhancements to wait-time reporting in Saskatchewan and Nova Scotia (e.g., new online search tool for finding a surgeon). In addition, we were pleased to discover that there are now five provinces reporting wait times for pediatric surgery: Ontario, New Brunswick, Alberta, British Columbia and Quebec.

Table 3: 2013 rating of provincial wait-time websites (maximum five points for each of the five criteria)*

Province	Timeliness	Comprehensive-ness	Patient friendli-ness	Perfor-mance	Quality/reliability	Average score	2013 grade	Best practices / comments
SK	4	4	4	4.5	4	4.1	A	Major improvements to web-site; timely data; comprehensive; patient friendly; helpful body diagram and listing by specialist; should be expanded beyond surgical services to include emergency department (ED) wait times
BC	4	4	4	4.5	4	4.1	A	Comprehensive; patient friendly; offers multiple ways to assess performance; helpful body diagram and listing by specialist; should be expanded beyond surgical services to include ED wait times; should present trend data beyond five initial areas
ON	4	4.5	3	4	5	4.1	A	Very comprehensive; includes ED wait times and strong reporting on cancer wait times; provides strong trend data; should be expanded beyond surgical services; could be more patient friendly (e.g., there are some broken links, and many clicks are required to get to data)
NS	3	4.5	4	4	4	3.9	B	Strong presentation (generally patient friendly); leader in reporting beyond surgical services, but more information on performance reporting is required
AB	4.5	4	4	3	4	3.9	B	Some portions are patient friendly; should provide more detailed wait times for cancer care and trend data for all procedures; appreciate ability to review wait times by urgency category.

QC	4	3	3	5	4	3.8	B	Improvement over 2012, with inclusion of hospital-specific data; data are timely, but should be more comprehensive; text very small.
NB	3	4	4	4	4	3.8	B	Strong in providing trend data; generally patient friendly; should identify numbers of patients treated and waiting.
NL	2	2	4	4	4	3.2	C	Patient friendly; should include wait times beyond the five priority areas; should release information on a quarterly basis.
MB	4	2.5	3	2	4	3.1	C	Timely; should provide information on greater range of services; should provide multiple ways to assess performance; should include trend data and links to benchmarks or targets.
PEI	3	1	3	4	4	3.0	C	Good performance reporting but can be difficult to know where to find information suitable for patients; list of reported services should be expanded.
Overall national grade						3.7	B	

*Scoring for Wait Time Alliance rating of provincial wait-time websites: maximum of five points for each of the five criteria (perfect average score = 5).

The overall 2013 grade for provincial websites is B, the same as in 2012. Three provinces received an A grade: Saskatchewan, British Columbia and Ontario. Although the provincial websites have improved over the past five years, the WTA suggests that it is time to raise the bar in provincial reporting:

- For most websites, ease of use should be improved, with patients, families and providers in mind as their main users. For example, some websites do not offer larger fonts for those with visual disabilities or are difficult to use for those with a disability associated with brain injury.
- Better promotion to the public is needed for most websites.

- For almost all websites, the scope of services listed should be increased. Most do not go beyond a limited range of surgical procedures, but various other services, such as gastroenterology, psychiatric care and emergency care, should be included.
- Reporting of wait times for cancer care (specifically radiation therapy) is minimal in most provinces, and only Ontario and Manitoba provide wait times by body site.
- Although some standardization exists, much more information is needed to allow proper assessment of wait times. For example, some provinces provide wait times separately for inpatients and outpatients and by urgency categories, whereas many provinces combine all patient and urgency categories.

Some examples of best-in-class public reporting appear in Table 4.

3. Making structural changes to sustain decreases in wait times

Reductions in wait times have plateaued in many jurisdic-

tions. Despite the fact that provincial governments have poured much additional funding into the health care system to reduce wait times, reductions have been temporary and/or minimal. So what is the best way forward? The WTA believes that the best way to make sustained reductions in wait times is to implement structural changes in how we mitigate, measure, monitor and manage wait times (an approach first

Table 4: Best-in-class provincial public reporting by procedure

Procedure	Best example of reporting	Strengths of reporting
Cancer care (radiation therapy)	Ontario	Identifies wait times by body site and includes waits for both consultation and start of treatment.
Cataract surgery	Saskatchewan	Separates wait times for elective and urgent cases.
Emergency department wait times	Ontario	Identifies percentage of patients treated by all 10 urgency categories.
Diagnostic imaging	Ontario	Offers ability to separate data for inpatients and outpatients.
Coronary artery bypass grafting (CABG)	Alberta	Calculates wait time from date of cardiac catheterization or from date of alternate imaging to date of surgery. If no imaging is performed, wait time begins at date of referral to surgery. This method provides a more accurate account of the patient's wait than methods used by other provinces. In addition, the WTA commends Alberta for its target of 6 weeks for non-urgent CABG.
Specialist consultations	Nova Scotia and Saskatchewan	Nova Scotia was the first province to report on consultation wait times for selected specialties and is the only province to list wait times for consultations for cardiac rehabilitation and electrophysiology. Saskatchewan reports on wait times to access specialist consultation for all reporting specialties (although wait times vary widely at this point).

Table 5: Examples of structural changes/strategies that could improve timely access

Category	Examples of strategies
Mitigate wait times	<ul style="list-style-type: none"> • Health promotion and disease prevention strategies (e.g., diet, physical activity, smoking) • Appropriateness guidelines and clinical prioritization tools to improve understanding of the patients for whom treatment will be appropriate and to improve referrals for specialty care and diagnostic testing*
Measure wait times	<ul style="list-style-type: none"> • Standardized definitions for wait times that reflect the patient's journey and that can be properly assessed and monitored; should include wait time for health care services beyond surgery (e.g., home care)* • Common urgency measures within and across procedures*
Monitor wait times	<ul style="list-style-type: none"> • Ready accessibility of wait-time information to patients and providers • Regular reporting of wait times using easy-to-understand indicators • Provision of options for patients who seek quicker access elsewhere
Manage wait times	<ul style="list-style-type: none"> • Advanced-access booking to allow for same-day appointments in primary care settings • Centralized intake systems for accessing specialty care, where feasible • Partial activity-based funding for hospitals, to facilitate increases in volume of procedures • Optimization of use of operating rooms and diagnostic equipment • Adequate community health and social services to reduce wait times for patients waiting to leave acute care beds (i.e., patients needing alternate levels of care)*

*Specific examples outlined in accompanying text.

Table 6: Pan-Canadian MRI and CT wait-time benchmarks, as set by Canadian Association of Radiologists

Priority categories	Target for maximum wait time
Priority 1 (P1) Emergent: an examination necessary to diagnose and/or treat disease or injury that is immediately threatening to life or limb.	P1: Same day — maximum 24 hours For emergent/life-threatening conditions, some patients require imaging in even less than an hour, and such decisions are based on the clinical team’s judgment.
Priority 2 (P2) Urgent: an examination necessary to diagnose and/or treat disease or injury and/or alter treatment plan that is not immediately threatening to life or limb. Based on provided clinical information, no negative outcome related to delay in treatment is expected for the patient if the examination is completed within the benchmark period.	P2: Maximum 7 calendar days There is a spectrum of “urgency” within the urgent category. In most instances, the exam should be completed as soon as possible after the referral is received. However, in some cases (depending on medical need as determined by the clinical team’s judgment), while the need is still urgent, a maximum wait time of seven days may be medically acceptable.
Priority 3 (P3) Semi-urgent: an examination necessary to diagnose and/or treat disease or injury and/or alter treatment plan, where provided clinical information requires that the examination be performed sooner than the P4 benchmark period.	P3: Maximum 30 calendar days
Priority 4 (P4) Non-urgent: an examination necessary to diagnose and/or treat disease or injury, where, based on provided clinical information, no negative long-term medical outcome related to delay in treatment is expected for the patient if the examination is completed within the benchmark period.	P4: Maximum 60 calendar days
Specified procedure Date MRI or CT scan appointment date requested by the ordering physician for the purpose of disease surveillance.	It is recommended to track performance against specified dates, as poor performance in P1–P4 categories may alter performance in this category, creating a serious concern in patient care for which strategies should be developed.

* Source: Canadian Association of Radiologists.¹⁹

introduced by the WTA as the 4-M Toolbox of strategies¹). Table 5 lists examples of the types of structural change that could be undertaken.

Certain of the structural changes listed in Table 5 are already in place in some locations. In some of these cases, the changes are being led by provincial governments. For example, activity-based funding for hospitals has been introduced in a few provinces, such as Ontario and British Columbia, whereas Saskatchewan has initiated the Saskatchewan Surgical Initiative to improve surgical patients’ care experience and to ensure that, by 2014, all patients will have the option of receiving their surgery within three months. Other organizations are contributing as well. For example, the Health Council of Canada has established the Health Innovation Portal (<http://innovation.healthcouncilcanada.ca/>), a website that serves as a clearing house for innovative health care practices, policies, programs and services from across Canada. The website includes a searchable database of innovative practices.

WTA members are leading some of the necessary structural changes, as highlighted briefly below.

New wait-time targets and appropriateness guidelines for diagnostic imaging

The Canadian Association of Radiologists (CAR), the national association representing radiologists in Canada, has recently taken steps to mitigate, and to improve the measurement of, wait times. In a recent report, *National Maximum Wait Time Access Targets for Medical Imaging (MRI and CT)*,¹⁸ the CAR recommends new standardized definitions for use of medical imaging (MRI and CT) and also recommends how wait times are to be measured, tracked and reported to ensure consistent pan-Canadian collection and reporting of data. Other recommendations touch on enhancing the appropriateness of each patient’s imaging care and turn-around times for medical reports. In a five-point priority classification system, the CAR recommends new benchmark target times

for MRI and CT examinations to ensure timely access based on medical need (see Table 6). The CAR has also produced guidelines for diagnostic imaging referral to assist physicians in making appropriate referrals for diagnostic imaging for specific cases.¹⁹ The guidelines and updated benchmarks serve as essential counterparts.

The CAR's work to update its benchmarks for MRI and CT can serve as a model for other specialty societies in reviewing their own benchmarks or for any national specialty organization that is considering developing its own benchmarks.

Improving access for pediatric surgery patients: Paediatric Canadian Access Targets for Surgery (P-CATS)

Canadian children and youth represent more than one quarter of the population.²⁰ Children and youth often require surgery at critical stages of development. Delaying surgery could have lifelong and permanent impact. Furthermore, research and experience have shown that taking care of our children and youth through early identification and intervention can not only reduce negative health outcomes but may reduce the lifelong burden including the cost of care over the patient's lifetime.²¹

The Canadian Paediatric Surgical Wait Time (CPSWT) Project developed a prioritization system for surgery called the Paediatric Canadian Access Targets for Surgery (P-CATS) encompassing 867 diagnoses in 11 surgical disciplines. There is general agreement that a shared language in health care (such as the shared classification of diseases) is beneficial. A common language allows shared learning, not only through the development of the methodology itself, but also by allowing stakeholders to learn from one another how to interpret and respond to the resulting data. P-CATS was developed for clinicians by clinicians (specifically pediatric surgeons from Canadian pediatric centres). The advantage has been to create clinically relevant and useful access targets for clinical decision-making in the management of wait times (i.e., "to do the right case at the right time"). As pediatric surgery is highly specialized, a common methodology has also allowed hospitals to collaborate to identify areas of common need and leverage possible solutions.

P-CATS was developed by expert panels of over 100 pediatric surgeons from all surgical subspecialties from across Canada. Using this methodology, children with the same

diagnosis are assigned the same priority (i.e. access target wait time) regardless of where they live in Canada. By attaching one priority to each diagnosis and using consistent priorities across all surgical subspecialties, P-CATS generate data that is less prone to variance in practice.

The CPSWT Project has:

- Developed and implemented a common methodology to measure, monitor and manage surgical wait times for children and youth.
- Created a central database containing wait-time data and trends for approximately 289,000 pediatric surgical cases.
- Provided actionable management information for its participating hospitals to improve access to surgical care for their patients.

At a national level, the CPSWT database represents the only source of comprehensive, *comparable* pediatric surgical wait time information from currently available in Canada. The data from January 2012 to December 2012 demonstrated that on average, 31% of pediatric patients received surgery past their access targets (i.e., acceptable wait times).²²

At the local level, hospitals participating in the project have reduced the percentage of children exceeding acceptable wait times by using this system to prioritize cases by acuity and redistribute resources to address their specific areas of need. At one hospital P-CATS are used by individual surgeons to prioritize patients on their surgical lists. At another hospital, P-CATS are used to allocate operating room time among surgical divisions. Finally, at a third hospital, P-CATS were used to determine the greatest need for additional operating room (OR) time. With additional funding from the Ontario Ministry of Health and Long-Term Care their overall rate of pediatric patients receiving surgery past their access targets dropped from 46 to 15%. Using common standards also enabled participating hospitals to share learning.²²

In 2009 the project was awarded the Gold Leadership Award by the Institute of Public Administration of Canada for its vision, innovation, leadership and collaboration. The value of the project has been recognized by many provinces across the country. For example, the Ministry of Health of British Columbia has adopted P-CATS to measure wait times for all pediatric surgeries across the province. The Patient Access Registry of Nova Scotia (PAR-NS) incorporates P-CATS-coded pediatric information from the IWK Health Centre for approximately 70% of Nova Scotia's pediatric surgery cases. Finally, in a recent initiative in Alberta, P-CATS is being considered as a model to develop similar targets for adults.

The CPSWT Project was funded by Health Canada through contribution agreements under the Health Care Policy Contribution Program* from January 2007 to March 2011 and has self-sustained since through participating site contributions. Due to a lack of continued funding, on April 1, 2013, the CPSWT Project transitioned benchmark reporting for completed cases to the Canadian Association of Paediatric Health Centres—Canadian Paediatric Decision Support Network (CAPHC—CPDSN).† Data is submitted under special project fields to CIHI’s Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) databases. While grateful for CAPHC—CPDSN and CIHI’s support, unfortunately due to funding, the CPSWT benchmark reporting was sustained on a much reduced scale.

However, this project serves as a strong example of how national professional collaboration and leadership can lead to the development of a standardized methodology to measure, monitor and manage wait times in a multitude of centres across jurisdictions.

Models of care in orthopedics: a grassroots endeavour

The Canadian Orthopaedic Association (COA) and its partner, Bone and Joint Canada, have developed a highly successful process for creating patient-centred models of care for hip- and knee-replacement surgery, which can be adapted to accommodate regional variance in the delivery of orthopedics care. Inspiration for this approach came from the fast-food service industry, where many small steps are coordinated and timed to allow delivery of custom orders to consumers hundreds of times a day.

To match that level of efficiency and productivity requires careful planning and clear directives, such that the 50 or more health care professionals and technicians who look after a single joint-replacement patient can function in a truly integrated and timely fashion. As a result, the development process for the model of care and the realignment of resources that ensues must necessarily be developed from the ground up.

Often the solution involves minor reorganization and communication that in and of themselves have little impact,

but that increase exponentially in value when they are integrated with many other bits of reorganization and communication. Best practices are identified and posted in an online “toolkit,” which allows front-line workers to choose from a menu of solutions that can then be customized to local circumstances.

One such best practice that is now common in many centres across Canada is the total joint assessment clinic. Patients who are referred for orthopedic specialist care are triaged at the clinic before the first consult (often by advanced practice physiotherapists). Up to 30% of referred patients are not candidates for surgery, and these patients can be directed toward more appropriate care, resulting in greater efficiency and high patient satisfaction.

In all 10 provinces, a knowledge network of administrative and clinical leaders has been applying this approach to hip- and knee-replacement surgery, striving for uniform practice and national standards set by the network itself. Although by no means uniform across the country, the resulting efficiencies can shorten a patient’s length of stay in hospital, reduce costs and create the lasting benefit of a multidisciplinary knowledge network where there was previously none. In short, this model of care delivers significantly better value for health dollars spent on joint-replacement surgery.

The same methodology should work in all areas of musculoskeletal care — and probably in all areas of health care. Currently, various clinical groups are using the COA’s approach to develop models of care for hip fractures, back injury, and foot and ankle problems. For example, under the aegis of the Arthritis Alliance of Canada, which brings together 35 stakeholder organizations (including the COA), this process is now being applied from the bottom up to the entire range of arthritis and musculoskeletal conditions.

Improving wait times for specialty referrals and consultations

Physicians in all areas of the country experience a multitude of challenges at both ends of the patient referral. Many initiatives are under way in Canada with the goal of addressing these challenges, but knowledge about these activities is limited.

* Financial support for this project was made possible through Health Canada’s Health Care Policy Contribution Program, via the Canadian Paediatric Surgical Wait Times Projects. The views expressed herein do not necessarily represent the views of Health Canada.

† As of April 1, 2013, the decision-to-treat date, the surgery date, and the P-CATS code for completed pediatric surgical cases across Canada can be submitted to CIHI through the DAD and NACRS databases. The CAPHC-CPDSN has agreed to create reports for their members, which will be published in their annual report.

To help raise awareness, the CMA, with funding from Health Canada and assistance from the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada, has created the Referral and Consultation Process Toolbox (www.cma.ca/referrals). This toolbox is an online collection of successful initiatives for improving the referral and consultation process, grouped into four categories: Intraprofessional Communications, Measuring Wait One, Central Intake and Physician Directories.

In addition to showcasing success stories in these areas, “how-to” guides are provided, wherever possible, to assist interested parties in creating their own successes in their respective jurisdictions and practices. For example, a six-step guide to creating a central intake program was developed with input from those involved in orthopedic central intake systems around the country.

Concise summaries of nearly 30 initiatives aimed at improving specialty referrals and consultations can be found in a document located on the main page of the toolbox via the link Referral and Consultation Process Improvement Projects.

A physician survey conducted in fall 2012 found that of those who were aware of the toolbox, 76% found it useful and 20% had been motivated to implement new ways to approach the referral and consultation process.

The Referral and Consultation Process Toolbox is a “living resource” that will grow and evolve as new approaches to improving the referral and consultation process are discovered.

The need to improve access to community care

The WTA’s 2011 and 2012 report cards identified the urgent need to address the impact of ALC on wait times. In fact, the WTA has previously stated that addressing the ALC issue constitutes the most important action to improve timely access to specialty care for Canadians. ALC is generally used to describe patients who continue to occupy an acute care hospital bed after the acute phase of their inpatient stay is complete.²³ ALC patients are deemed well enough to be cared for elsewhere, with the exact location depending on their particular situation. ALC patients accounted for 5% of admissions to hospital and 14% of hospital days in acute care facilities in Canada in 2007–2008. This means that, on any given day, almost 5,200 beds in acute care hospitals were occupied by ALC patients.²³ The impacts of this high number

of ALC patient can include long wait times and overcrowding in the ED, as ED patients cannot be admitted to hospital beds occupied by ALC patients; delays in accessing paramedic services; last-minute cancellations of scheduled surgeries; and even longer waits for urgent surgeries that require an intensive care unit bed.

Numerous factors contribute to the ALC crisis. Patients with dementia accounted for almost one-quarter of ALC hospitalizations and more than one-third of ALC days.²⁴ The WTA’s 2012 report card identified the need for solutions to the high numbers of ALC patients at the community, hospital and residential (i.e., long-term care) levels. Such solutions might include taking a more proactive approach to the ALC issue — looking upstream, through better early identification of those at risk for ALC status, and treating them in ways that prevent unnecessary deterioration.

For elderly patients for whom admission to hospital is appropriate and unavoidable, acute care hospitals must develop screening approaches to detect those at highest risk of an ALC stay. Such approaches will invariably include screening for delirium and dementia, as well as early and aggressive mobilization. Screening and intervention for ALC risk should be applied as early as possible during the admission and should trigger rapid assessment and intervention by the most appropriate service (e.g., geriatric medicine, care of the elderly, psychiatry), even if the patient is still in the ED awaiting a hospital bed.

In addition, Canada needs to adopt a National Dementia Strategy that formally integrates the functions of primary care, specialist care and home care services, with a strong focus on keeping elderly people in the community (out of the ED and out of hospital) and preventing or delaying placement in long-term care.⁵ Such a strategy would decrease the impact of dementia on ALC rates by preventing ED use or hospital admission and by freeing up beds for patients for whom placement in long-term care is truly unavoidable. The call for a National Dementia Strategy was subsequently endorsed by the CMA General Council in August 2012. CMA has also submitted a brief to the federal government calling for federal funding to address the shortfall in infrastructure capacity in Canada’s long-term care sector (both to build new facilities and to upgrade existing ones).²⁴

Despite the impact that continuing care can have on Canadians’ ability to access other components of the health care system, only a few provinces currently report on wait times for home care services or placement in a long-term care facility.

Other examples of structural changes to improve Canadians' timely access to care

Providing timely access to necessary care is a shared responsibility. Governments have a role to play, for example, by adequately funding the system and supporting other stakeholders in making process improvements (e.g., through standardization). Providers are also part of the overall solution to improve the performance of the health care system. WTA members acknowledge that they must work collaboratively with other health care providers, patients and governments to help Canadians attain timely, appropriate and equitable access to high-quality, patient-centred health care. WTA members are assisting in such efforts in a variety of ways, such as:

- Identifying best practices in improving access to quality care across Canada (such as care pathways, referral pathways and checklists embedded in electronic medical records) and sharing these best practices to bring about positive change.
- Identifying structural reforms that affect access, such as advanced-access models and multidisciplinary teams.
- Contributing toward the collection of wait-time data.

Details on other WTA-led projects now under way to better manage wait times are available on the WTA website: www.waittimealliance.ca/leading_practices_e.htm.

About the Wait Time Alliance

The Wait Time Alliance (WTA) was created in the fall of 2004, following the release of that year's Health Accord (*A 10-year plan to strengthen health care*). WTA members have used their unique expertise to develop and advocate for medical wait-time benchmarks, as well as to monitor governments' implementation of wait-time commitments.

WTA mission statement: The WTA is concerned over delayed access to health care for Canadians. We work collaboratively with our stakeholders to inform, advocate and provide solutions to achieve timely, appropriate and equitable access to high-quality health care.

The WTA is comprised of 14 national medical organizations whose members are directly involved in providing care to patients:

- Canadian Anesthesiologists' Society (CAS) — www.cas.ca
- Canadian Association of Emergency Physicians (CAEP) — www.caep.ca
- Canadian Association of Gastroenterology (CAG) — www.cag-acg.org
- Canadian Association of Paediatric Surgeons (CAPS) — www.caps.ca
- Canadian Association of Nuclear Medicine (CANM) — www.canm-acmn.ca
- Canadian Association of Radiation Oncology (CARO) — www.caro-acro.ca
- Canadian Association of Radiologists (CAR) — www.car.ca
- Canadian Cardiovascular Society (CCS) — www.ccs.ca
- Canadian Medical Association (CMA) — www.cma.ca
- Canadian Ophthalmological Society (COS) — www.eyesite.ca
- Canadian Orthopaedic Association (COA) — www.coa-aco.org
- Canadian Psychiatric Association (CPA) — www.cpa-apc.org
- Canadian Society of Plastic Surgeons (CSPS) — www.plasticsurgery.ca
- Society of Obstetricians and Gynaecologists of Canada (SOGC) — www.sogc.org

In addition to these members, the WTA is partnering with a number of other organizations including the College of Family Physicians of Canada, the Canadian Geriatrics Society and the Canadian Association of General Surgeons.

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