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Introduction and Wait Time Overview

Access to care is most broadly defined as “the degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system.”¹ Access is influenced by many factors, but from the patient’s perspective, perhaps the most important is how long they must wait for the care they need. Not all waits are created equal: some may be necessary from a clinical perspective, while others are more simply an inconvenience. But some waits can have negative consequences for patients. Research has shown that long waits for care can contribute to declines in health status and poorer outcomes of care, and can impact the health care system overall. When asked, Canadians report that such waits lead to increased worry, anxiety, stress and pain.²

Over the past decade, access to care, and specifically wait times, has received increasing attention from government, health system decision-makers, the media and the general public. When concerns were initially raised about how long patients were waiting to receive care, there was little comprehensive, comparable national data to inform the debate. Although some gaps remain, much progress has been made in measuring and reporting on wait times, particularly for areas identified as priority.

Health Care in Canada, 2012: A Focus on Wait Times highlights what is currently known about the waits patients experience in different settings across the health care continuum. In this introduction, a description of the evolution of wait time measurement and reporting is presented, including areas where measurable progress has been made. As well, the effectiveness of adding more resources as a means to reduce waits within the health care system is examined. By bringing together data, previous research and evidence from scientific literature, this introduction sets the stage for the remainder of the report, which discusses areas of Canada’s health care system that would benefit from a focus on wait times.

Resources and Wait Times

Although not alone in its challenges to providing appropriate and timely access to health care services, Canada lags behind other countries. A 2010 survey ranked Canada lowest among 11 countries for wait times in the following areas:

- **Seeing a doctor or nurse when sick:** 33% of patients surveyed reported waiting six days or more for an appointment, 5% more than the country ranked second-lowest;
- **Seeing a specialist:** 41% reported waiting two months or more, 7% more than the country ranked second-lowest; and
- **Having elective surgery:** 25% reported waiting four months or more, 3% more than the country ranked second-lowest.³

An often suggested approach to improve wait times is to increase associated resources for providing the care. Canada has historically ranked below other Organisation for Economic Co-operation and Development (OECD) countries on several key indicators of available resources for health care services, such as number of beds per population, bed occupancy rate and diagnostic imaging rates. Over the past decade, significant efforts have been made in Canada to increase health care resources, with the goal of improving access and shortening wait times. In the 2000s, several policy changes were implemented to increase the number of physicians working in Canada (for example, facilitating internationally trained physicians working in Canada and increasing the number of seats in faculties of medicine).⁴

In 2003, the OECD undertook a study of countries that publicly report on wait times to understand whether greater availability of resources was associated with shorter waits for elective surgeries (such as knee replacement and cataract removal). Resource measures such as overall health care funding, number of hospital beds, and number of physicians and how they are remunerated were found to be important contributors (in varying degrees) to wait times but on their own did not translate directly to better access to care or shorter wait times.⁵

The Canadian Institute for Health Information (CIHI) used the same methodology employed by the OECD to examine variations in waits across Canada's 10 provinces, considering the following resource measures:

- Funding (per capita health expenditure);
- Capacity (number of acute care beds, overall number of physicians and specialist physicians);
- Hospital activity (bed occupancy rate, number of inpatient and day surgeries); and
- Operating room activity (unit-producing personnel hours).

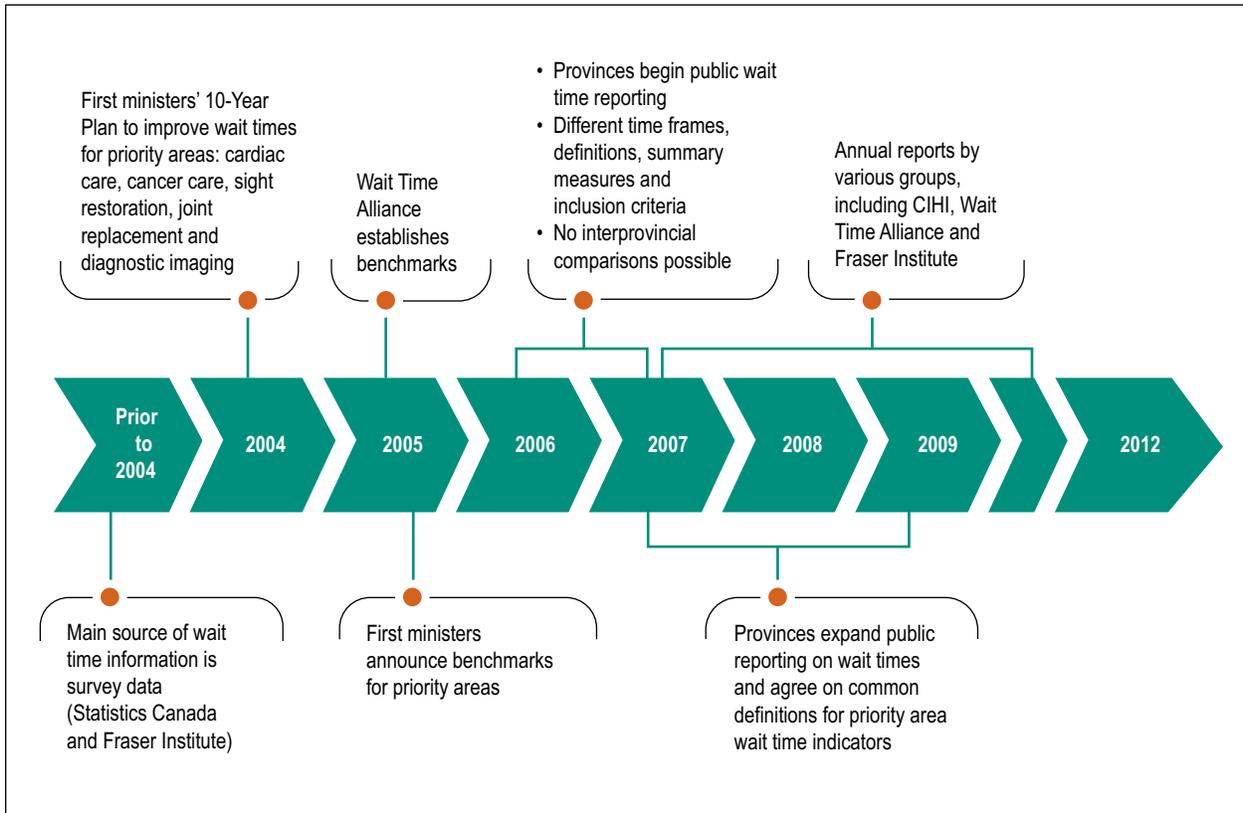
The results of CIHI's analysis of Canada's data supported the OECD's finding that more system inputs do not necessarily translate directly to better access to care or shorter wait times. Interrelated factors, however—differences in policies and procedures, strategies and care delivery structures, supply and demand management, efficiency and productivity issues, appropriateness and utilization rates, and the incentives/disincentives inherent to different funding models—may influence wait times across provinces. With governments facing constraints on health care spending, it would be helpful to look beyond increased spending for other strategies to improving access to care.

Agreements to Reduce Wait Times in Canada

In 2004, Canada's first ministers recognized wait times as a priority in the 10-Year Plan to Strengthen Health Care. The wait time component of this accord prioritized five clinical areas for achieving wait time reductions: cardiac care, cancer care, diagnostic imaging, joint replacement and sight restoration. The first ministers agreed to work toward meeting evidence-based benchmarks for medically acceptable waits, which were established in late 2005 for some priority procedures. A timeline was set for achieving meaningful reductions but allowed for each jurisdiction to pursue its own strategy with target setting and annual reporting. CIHI was tasked with reporting on progress on wait times across jurisdictions.⁶

The \$41 billion in federal funding in support of the 2004 health accord included a \$5.5 billion Wait Times Reduction Fund to augment existing provincial and territorial investments in reducing wait times in the priority areas. The federal government committed to investing \$4.25 billion over five years, beginning in 2004–2005. These funds were made available to provinces and territories on an equal per capita basis to be drawn down at the discretion of the provinces. Beginning in 2009–2010, the remaining \$1.25 billion was provided to the jurisdictions through a Wait Times Reduction Transfer of \$250 million annually.⁷ The primary uses of the Fund were designated as follows: for priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, and expanding appropriate ambulatory and community care programs and tools to manage wait times.⁶ The federal government also provided \$1 billion in support of Patient Wait Times Guarantees (PWTG), comprising \$612 million for the PWTG Trust, \$400 million for guarantee-related investments via Canada Health Infoway, and up to \$30 million for the PWTG Pilot Project Fund, a contribution program that allowed jurisdictions to pilot and test approaches to putting their guarantees in place.⁸

Figure 1: Evolution of Wait Time Measurement and Reporting in Canada



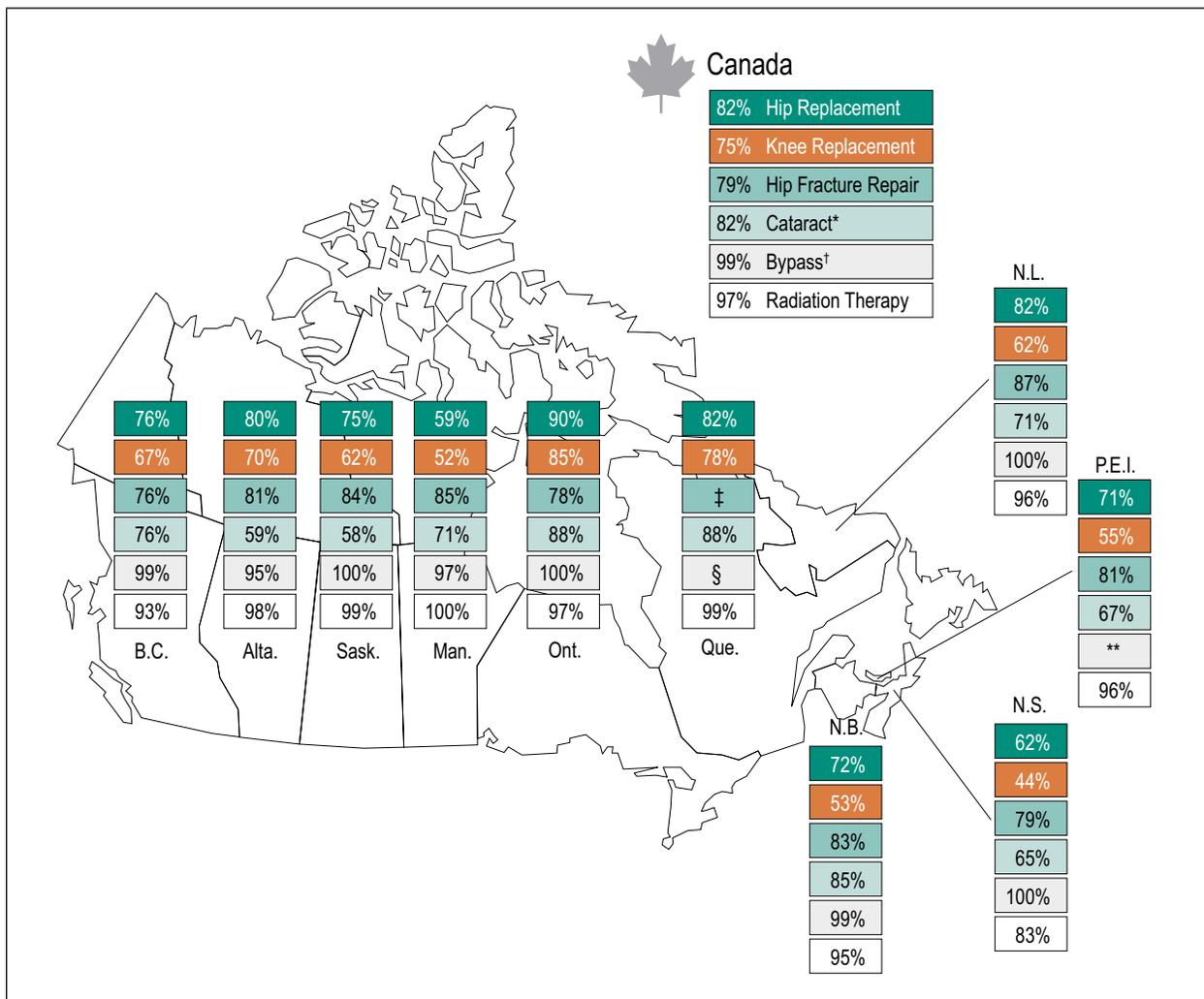
Source

Canadian Institute for Health Information.

Tracking Progress on Wait Times in Priority Areas

At the time of the 2004 health accord, information on how long Canadians waited for care was limited. With improvements in measuring and reporting wait times, progress can now be tracked for many priority procedures. Certainly the largest gains in wait time reductions were observed in the first years following the start of the 10-Year Plan; in more recent years, the gains have levelled off for the majority of procedures. Overall, by 2011, about 80% of Canadians were receiving priority procedures within the benchmark time frames; across the provinces, however, variation remains (see Figure 2).⁹

Figure 2: Proportion of Patients Receiving Care Within Benchmarks, Canada, and by Province and Priority Area, April 1 to September 30, 2011



Notes

- * The pan-Canadian benchmark specifies cataract surgery within 16 weeks (112 days) for patients who are at high risk. There is not yet consensus on a definition of “high risk,” so the benchmark is applied across all priority levels.
- † The pan-Canadian benchmark specifies bypass surgery within 2 to 26 weeks (14 to 182 days), depending on how urgently care is needed. As there is a lack of comparability for urgency levels, provinces are reporting the percentage of patients treated within a 6-month time frame.
- ‡ Quebec wait times for hip fracture repair are not included due to methodological differences in the data. For information on Quebec hip fracture wait times, see CIHI’s report *Comparing Wait Times for Hip Fracture Repair in Quebec With Those in Other Jurisdictions*.
- § Quebec reports the percentage of bypass patients receiving care within the benchmark for their assigned urgency level.
- ** P.E.I. does not offer cardiac services; patients receive care out of province.

Source

Canadian Institute for Health Information.

Beyond Priority Areas: Waiting Across the Continuum of Care

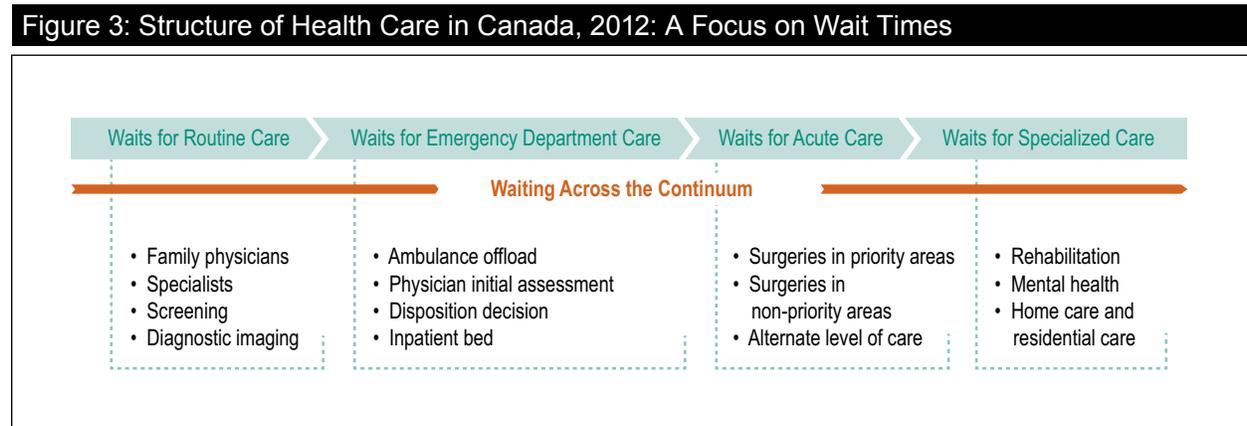
Focusing on reducing wait times for specific priority areas has yielded some encouraging results to date. However, Canada's health care system encompasses a wide range of services beyond surgeries and diagnostic imaging. Many have called for a more integrated approach to examining wait times across the continuum of care, to understand from a patient's perspective what it really means to wait for health care services, and to implement proven strategies on a wider scale.¹⁰⁻¹³ Moving forward requires a comprehensive review of the current state of knowledge.

Health Care in Canada, 2012: A Focus on Wait Times broadly describes waits across different dimensions of the health care continuum, as experienced by the patient. The report contains four chapters, each describing what is currently known about selected waits experienced for a particular segment(s) of care, and identifying important data gaps. Each chapter also contains examples of initiatives that have been successful in improving wait times, including those that focus on financial incentives, human resources policies, technology, patient flow and efficiencies. Taken together, this information can help inform policy-makers' understanding of where some of the most significant waits are happening. The conclusion of this report summarizes the initiatives described in the chapters and suggests areas where policy-makers may consider targeting future knowledge-gathering efforts.

To highlight the patient perspective, the report features short vignettes throughout narrating the journey of a typical patient. **Hani's Story** follows a fictitious 55-year-old Canadian immigrant who has recently made his home on Vancouver Island. These vignettes illustrate Hani's patient experience across the health care continuum as he waits for knee replacement surgery. **Hani's Story** is also featured in an online companion product accompanying this report. This interactive timeline allows users to navigate Hani's experience waiting for care and to learn more about individual segments of his waits.



Figure 3 outlines the content of the report, by chapter. This structure appears at the beginning of each chapter.



Chapter 1: Waits for Routine Care

Chapter 1 contains information on waits that patients experience for routine care. It describes waits to see family physicians in primary care, provides information on waits to see specialists and highlights the role of referrals. Waits for select diagnostic imaging and screening tests are also discussed.

Chapter 2: Waits for Emergency Department Care

Chapter 2 describes wait times experienced in emergency departments, and the potential causes and consequences of long waits in this setting.

Chapter 3: Waits for Acute Care

Chapter 3 describes waits for services in acute care settings, including an examination of whether the focus on specific priority areas—which began in 2004—had an impact on access to other types of surgical care. The chapter concludes with a profile of patients who occupy acute care beds while waiting for an alternate level of care.

Chapter 4: Waits for Specialized Care

Chapter 4 describes waits for specialized care, including rehabilitation, mental health, and long-term care and home care. Where possible, it explores the waits experienced for both in-hospital and outpatient settings, and the factors influencing them.

Looking Back, Looking Forward

This conclusion summarizes the main findings of the report, as well as strategies that research suggests may facilitate shorter wait times. Both comparable data and an increased use of benchmarks are essential to measuring and evaluating progress of these strategies, all of which would benefit from a patient-centred focus in their development and implementation.

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