Wait Time Alliance
Report Card

Unfinished business

Report Card on Wait Times in Canada

June 2009

How much of human life is lost in waiting.

— Ralph Waldo Emerson

Overview

Canadians are used to waiting. They wait in line for coffee and for buses on the way to work. But waiting for health care is very different. Five years ago the governments of Canada resolved to improve wait times for health care by committing nearly $6 billion to the cause. Although there are signs of improvement, the lack of uniform and timely information on wait times is just one symptom of the 'unfinished business' relating to wait times in Canada. What's going on?

With an ever-expanding roster of wait-time benchmarks and data, the 4th Wait Time Alliance (WTA) report card gives Canadians a more accurate picture of the real wait times to access a broader range of medical care.

This report card is the first to go beyond reporting on access to the initial "5 priority areas" listed in the 2004 First Ministers Agreement: joint replacement (hip and knee); sight restoration (cataract surgery); heart (coronary artery bypass graft); diagnostic imaging (MRI and CT) and cancer care (radiation therapy).

The report contains four main sections: (1) Unfinished business — wait times for the five priority areas, (2) Expanding focus — the total wait for a wide range of specialty care services can be quite lengthy, (3) How long is the wait — better public information required and finally (4) Next steps.

Specifically, in the second section — (2) Expanding the focus— we have included data on total wait times for a broader range of services including:

- additional procedures under the initial 5 priority specialty areas;
- procedures/conditions for an additional 6 specialties, specifically: psychiatry, obstetrics/gynecology, gastroenterology, plastic surgery, anesthesiology, and emergency care.

The wait-time data for these additional procedures/conditions were collected from a WTA commissioned Ipsos-Reid study of 11 national specialty societies in February 2009. The findings reflect what a doctor may see in his/her practice starting from the time the patient is referred by their family physician. However, the length of wait time assessed in this report card does not include the wait patients may experience to access their family physician or the fact that nearly 5 million Canadians do not have a family doctor.

1. Unfinished business — Wait times for the 5 "priority areas"

As was the case in previous WTA report cards, the 2009 edition shows slight improvement over the previous year in wait times for the 5 priority areas (Table 1). This finding is based on the percentage of patients being treated within the government benchmarks. Ontario, Manitoba and BC continue to be strong performers while Atlantic Canada lags behind. However, these benchmarks represent maximum acceptable wait-time targets and should not be viewed as desired wait-time targets. Furthermore, these results can vary by region within a province (e.g., urban areas may have different access levels than rural areas).

There also remains concern with the benchmarks used by provincial and territorial (P/T) governments. For instance, governments' decision to focus only on establishing a wait-time target for access to cardiac bypass surgery (CABG) fails to recognize all the other components of cardiovascular treatment and care. These include but are not limited to patient access to a community cardiologist and diagnostic or therapeutic procedures, as well as to access to cardiac rehabilitation. Evidence-based benchmarks for access along this entire continuum of cardiovascular care were developed in 2005 by the Canadian Cardiovascular Society (CCS) and WTA. All these benchmarks must also be adopted in order to meaningfully address patient access to care. This includes adoption of the recommended benchmark of 6 weeks for CABG, compared with the current target of 26 weeks set by governments. Please refer to the CCS website at www.ccs.ca for a full range of benchmarks for cardiovascular services and procedures.

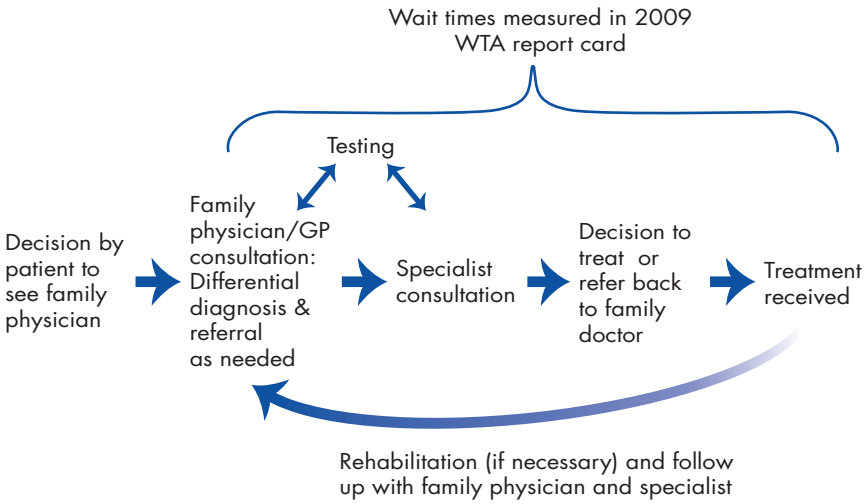
2. Expanding focus — The total wait for a wide range of specialty care services can be quite lengthy

The 2009 WTA report card attempts to gain a better understanding of the real wait experienced by patients. From the patient's perspective, the wait begins sooner than when an appointment for treatment is booked. Figure 1 shows the patient's total journey through the health system.

This year's report card also presents data that capture a more accurate assessment of the total wait time patients experience to access care for a number of specialty areas. This accounts for the time from when a patient receives a referral from their family physician to see a specialist until they actually receive the treatment required.

Specialists were requested to review the charts of their last 5 patients to see how long they waited from the time they saw their family physician to the time they got treated. This methodology was first developed and used by the Canadian

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*

Table 1. Provincial wait times compared to provincial–territorial govenment benchmarks

Province	CT		MRI		Hip		Knee		Radiation Oncology		Cataract		CABG*	
NL	nb	?	nb	?	B	⇧	C	⇧	A	⇩	A	⇩	A	⇩
PEI	nb	⇧	nb	⇔	na	?	na	?	A	⇩	na	?	/	/
NS	nb	?	nb	?	F	⇔	F	⇩	na	⇔	B	⇔	na	?
NB	nb	?	nb	?	C	⇔	D	⇔	A	⇩	B	⇔	A	⇔
QC	nb	?	nb	?	A	⇔	A	⇔	A	⇩	na	⇔	na	?
ON	nb	⇔	nb	⇔	A	⇩	A	⇩	A	⇩	A	⇩	A	⇔
MB	nb	⇩	nb	⇧	A	⇩	A	⇩	A	⇔	B	⇔	A	⇩
SK	nb	?	nb	?	C	⇔	F	⇔	A	⇩	A	⇩	A	⇔
AB†	nb	?	nb	?	na	?	na	?	na	?	na	?	na	?
BC	nb	?	nb	?	A	⇩	A	⇩	A	⇔	A	⇔	A	⇩
Annual National Wait Time Grades‡														
2007	nb	?	nb	?	B	⇩	B	⇩	C	⇩	B	⇔	A	⇔
2008	nb	?	nb	?	B	⇔	B	⇩	B	⇔	B	⇔	A	⇔
2009	nb	?	nb	?	B	⇩	C	⇔	A	⇩	A	⇩	A	⇔

Table 1 letter grading methodology — based on provincial websites as of May 2009:

- A: 80–100% 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: for situations where no data are provided, are out of date (i.e., older than 6 months) or where data do not lend themselves itself to estimates of performance as detailed below.

The diagonal line / in white squares indicates that the service is not provided (i.e., CABGs in PEI).

nb: 'no benchmarks' — benchmarks for diagnostic imaging in Canada have not yet been established. Where provinces have reported wait times a colour grade is assigned to note progress made over the last 12 months.

Table 1 colour grading methodology‡

This table identifies the change in wait times using the most recent publicly available data for each of the 5 priorities by province as follows:

- (?) insufficient data to make determination
- (⇩) decrease in wait times over the year
- (⇧) increase in wait times over the year
- (⇔) no significant change (i.e.,+ or - < 5% difference) over the year

*The category of bypass surgery (CABG above) represents only a small part of the full continuum of cardiac care 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 need to be adopted to meaningfully address wait times.

†As of June 2009, The Alberta Wait Time Registry website is down as data quality issues are being addressed in their IM/IT system.

‡Annual national wait time letter grades are based on a weighted average of provincial letter grades. The grade for each priority area is calculated by assigning points to provincial grades for each of the 4 graded procedures (A=4, B=3, C=2, D=1, and F=0), calculating the average, and then grading the average against the following system: A= 3.3-4.0, B= 2.5-3.2, C= 1.7-2.4, D= 0.9-1.6, F= 0-0.8.

Table 2. Summary for seven specialties included in the National Physician Diary Study

Specialty	Treatment/Procedure/ Subspecialty/Therapeutic /Diagnostic	Referral to consultation (median) in days	Consultation to treatment (median) in days	Total wait (median) in days	% of patients waiting longer than 18 weeks
Ophthalmology	Corneal transplant	62	457	636	na
	Adult strabismus surgery	159	188	450	91
Anesthesia	Chronic pain	na	na	106	44
Obstetrics and Gynecology	Abnormal premenopausal uterine bleeding	71	76	164	62
	Urinary incontinence	92	116	247	82
	Pelvic prolapse	93	120	250	77
	Pelvic pain	69	74	145	61
	Elective sterilization	80	64	159	64
	Combined	86	92	193	69
Nuclear Medicine	Thyroid studies and/or consultations	12	1	21	na
	Stress tests	25	0	25	na
	Isotopes therapy	16	0	19	na
Gastroenterology	Clinical features of significant active IBD	60	45	106	67
	Chronic diarrhea or chronic constipation	90	139	260	75
	Bright red rectal bleeding	37	14	57	43
	Fecal occult blood test positive	93	64	156	50
	Screening colonoscopy	106	39	148	60
	All conditions/ procedures	75	48	130	51
Plastic Surgery	All conditions/ procedures	55	87	173	59
Orthopedics	Total hip arthroplasty	65	141	247	75
	Total knee arthroplasty	89	143	312	83

Source: Ipsos-Reid Survey of physicians from 11 national specialty societies, February 2009.

*Overall in a survey field window of 3 weeks in February, 2009: 1,189 specialist physicians were surveyed on their views of wait times in Canada with wait time data collected on 2,010 patients.

Association of Gastroenterology (CAG). The WTA study represents the first time this methodology has been applied to multiple specialties.

These total wait times are then compared to appropriate maximum wait-time targets/benchmarks as follows:

- 18 weeks for scheduled care: Current provincial/territorial benchmarks reflect only the time patients wait for treatment after their specialist consultation. These benchmarks do not include the time patients spend waiting for the specialist consultation including all necessary diagnostic testing after being referred by their family physician. For comparison purposes, the WTA applied the target currently used by the English National Health Service (NHS): 18 weeks for scheduled surgery from the time the referral is made by the family physician to the day of treatment including all necessary diagnostic tests. This target is applied to procedures/conditions for 7 specialties in this report card;
- Cancer care: The Canadian Association of Radiation Oncology (CARO) benchmark of 4 weeks for radiation therapy (2 weeks for consult wait and 2 weeks for treatment) is used;
- Emergency care: With the exception of Ontario, governments provide no maximum wait-time targets for patients to receive emergency care. For comparison purposes, the WTA used the Canadian Association of Emergency Physicians (CAEP) benchmarks of 6 hours in 95% of cases for higher-level acuity patients (Levels I–III on the Canadian Triage and Acuity Scale — CTAS) and 4 hours in 95% of cases for lower acuity patients (CTAS levels IV–V);
- Psychiatry: The Canadian Psychiatric Association (CPA) 4-week maximum wait-time benchmark (scheduled cases) to access a psychiatrist for patients suffering from major depression is used.

Overall Physician Diary Study Results

The results, found in Table 2, include: the wait time between the referral from the family physician to the specialist visit; and the specialist consultation and any necessary diagnostic testing to the commencement of treatment. Based on the NHS target of 18-weeks from initial referral by a family physician to start of treatment, a majority of patients had wait times that exceeded the 18-week target (highlighted in red in the far right-hand column of Table 2). Access is particularly poor for: ophthalmology (adult strabismus), obstetrics and gynecology, gastroenterology, plastic surgery and orthopedics.

Cancer Care

According to the study results, the median wait for radical (curative) cancer care was 46 days or nearly 7 weeks. As Figure 2 demonstrates, the majority of these treatments exceeded the CARO benchmark for curative cancer treatment of 4 weeks (2 weeks for the consult wait and 2 weeks for treatment). This is troublesome given the clear link between a delay in radiation therapy and a chance of cure. With the exception of gastrointestinal cases, all forms of palliative cancer care were provided within the 4-week benchmark.

The big difference between curative and palliative care (Figure 3) is that the latter (usually) uses simple radiation techniques that need minimal planning and can often be scheduled at a few days notice. The radical (curative) treatments can be very complex and require a lot of resources (CT, MRI, radiation planning) all of which add significantly to the waiting.

Emergency Department Wait times

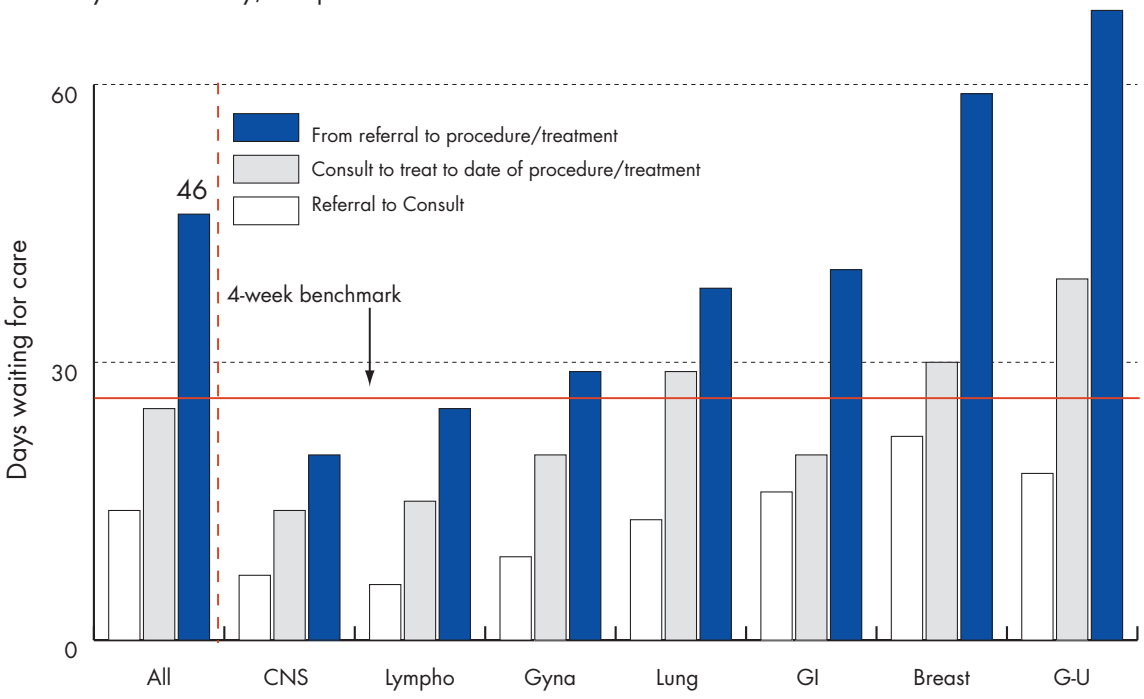
In regard to access to the emergency department (ED), the WTA compared the data to the CAEP targets: 6 hours in 95% of cases for high-level acuity patients (Canadian Triage and Acuity Scale (CTAS) levels I, II, III) and 4 hours in 95% of cases for less urgent and non-urgent patients (CTAS levels IV–V).[1] Please note that the CAEP targets are absolute maximum wait times as opposed to the median/average data collected by the WTA. This means that the numbers being reported below will have a range of patient waits embedded within them, with some patients waiting a shorter time and some patients waiting a longer time than the average or median wait time.

To be clear, these two CAEP target numbers reflect not the average wait time expected but rather the maximum acceptable length of stay. For example a higher acuity patient i.e. multiple injury car accident may be seen quicker but ultimately is waiting longer to get into an inpatient bed in the hospital. These higher acuity patients usually require a barrage of medical interventions to stabilize them before they are admitted to an inpatient bed (that has to be available or found) in the hospital, which is when their measured wait stops. This is why the maximum length of stay is longer for higher acuity patients.

The study found that the median wait time from the

Figure 2 Median Wait Time for Curative Cancer Care in Canada

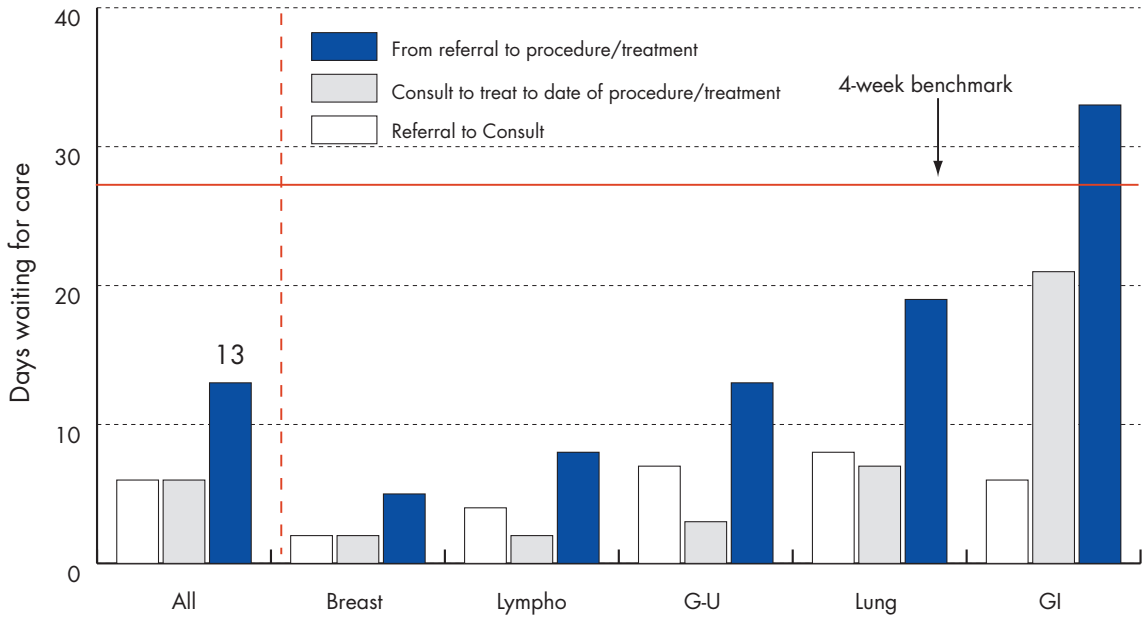
February 2009 survey; compared to the CARO 4-week benchmark



Source: Physician Diary Study, Ipsos-Reid survey, Canadian Association of Radiation Oncology, February 2009.
Abbreviations in the cancer care Figures above: Gyna= gynecological, CNS= central nervous system, GI= Gastrointestinal, lympho =lymphoma, G-U = Genito-Urinary, Lung=lung, Breast=breast

Figure 3 Median Wait Time for Palliative Cancer Care in Canada

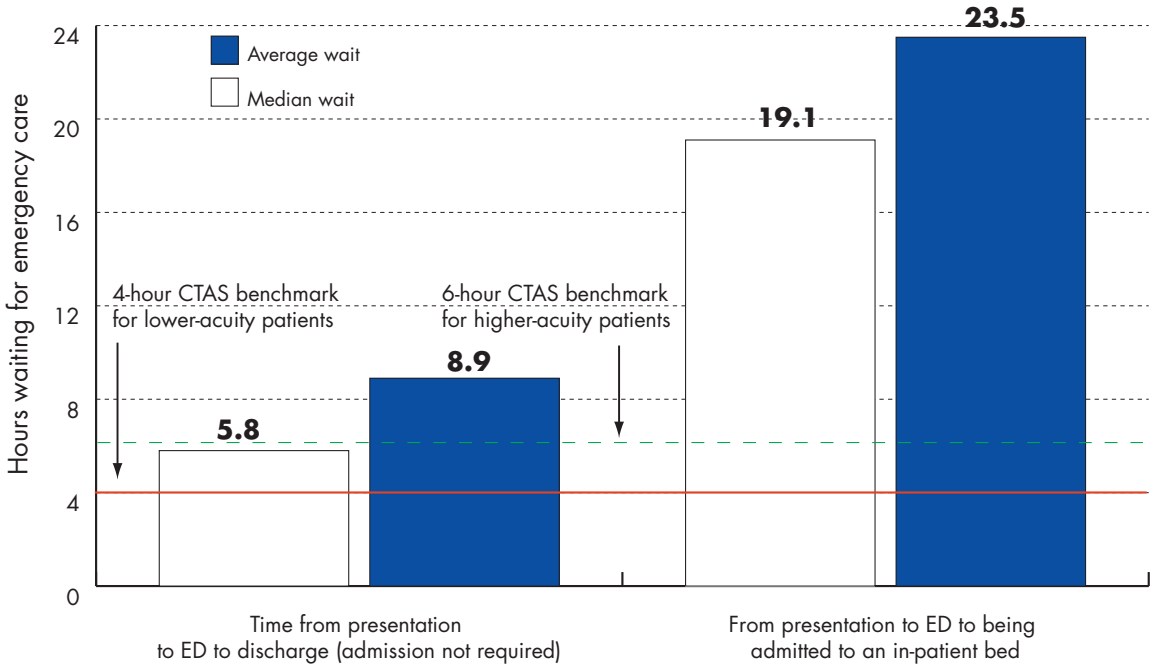
February 2009 survey; compared to the CARO 4-week benchmark



Source: Physician Diary Study, Ipsos-Reid survey, Canadian Association of Radiation Oncology, February 2009

Figure 4 Wait Times for Emergency Care in Canada

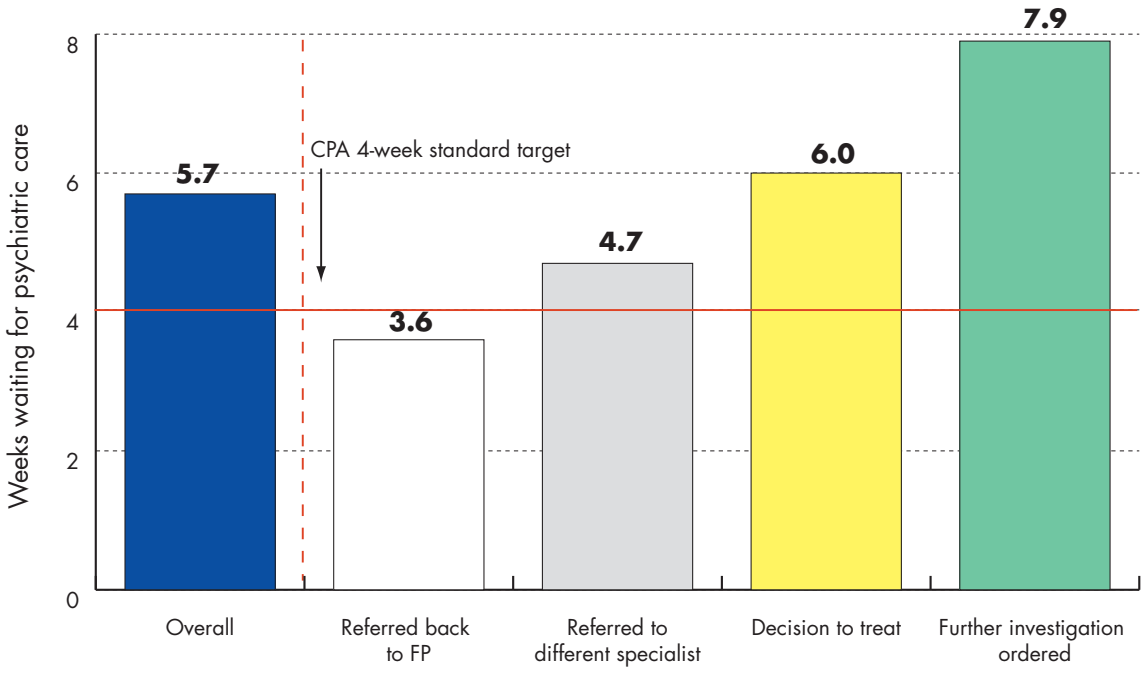
February 2009 survey data, compared to the 4- and 6-hour CTAS targets



Source: Ipsos-Reid Physician Diary Study, survey of Canadian Association of Emergency Physicians
ED time to discharge should not exceed 4 hrs/ and time to admission 6 hrs in 95% of cases — CAEP 09.

Figure 5 Wait Time for Psychiatric Care in Canada, outcome of consultation

February 2009 survey data, median wait times compared to 4-week target



Source: Ipsos-Reid Physician Diary Study, survey of Canadian Psychiatric Association.

time the patient presented at the ED to the time the patient was discharged (i.e., the patient did not need to be admitted to an inpatient bed) was almost 6 hours (see the lightly shaded bar on the left in Figure 4), while the average wait was nearly 9 hours.

Moreover, the median wait time for patients requiring an inpatient bed-that is, from the time the patient presented at the ED to the time they were admitted to an inpatient bed-was 19 hours (average is 23.5 hours or nearly one full day), which is substantially higher than the CTAS thresholds (e.g., more than three times the 6 hour guideline for high-level acuity patients). The longer wait for patients to be admitted is often due to the inability to find an available hospital inpatient bed.

Psychiatric Care Wait Times

With respect to timely access to psychiatric care, the overall median wait time to see a psychiatrist for major depression was 5.7 weeks which is almost 2 weeks longer than the Canadian Psychiatric Association's maximum wait-time benchmark of 4 weeks for scheduled cases (Figure 5). This median wait time is further clouded by the fact that psychiatrists are much more likely than other specialists to refuse accepting referrals: 37% of psychiatrists reported refusing to accept referrals very often or often, compared to 23% for all physicians.

3. How long IS the wait? — Better public information required

While there have been some improvements, wait-time information is not easily accessible or updated frequently enough in some provinces. Furthermore, there remains a lack of standard definitions in use among the provincial wait-time websites. One province-Newfoundland and Labrador-still does not have a web page dedicated to wait-times reporting. It also remains difficult for patients to obtain information on wait times for cancer care in some provinces (e.g., not having links between the main wait-time website and the provincial cancer care website). Having said this, it should be noted that some provinces have significantly improved the breadth and frequency of their data collection and reporting of wait times, particularly Ontario, Manitoba and New Brunswick.

Expanding the collection and reporting beyond the original 5 priority areas is urgently required. Enhanced reporting occurs in several provinces, but a few still report only on the initial 5 or on a limited selection of procedures.

Determining provincial/territorial progress on establishing wait-time guarantees is not possible, despite the commitment of governments to use an additional $612 million in federal funding to establish a guarantee for only 1 procedure per province by March 31, 2010.

4. Next Steps

While progress on access to timely care is being made in some specialty areas, there should be no move to ease up on these efforts. The WTA study also asked specialists for their opinion on future wait-times and 62% believe that wait times to access specialty care will increase over the next 5 years.

The WTA will continue to track provincial progress on the initial 5 priority areas announced as part of the 2004 First Ministers' *10-Year Plan to Strengthen Health Care*. In addition, the WTA will continue to shed light on: (1) the wait that patients experience for a wider range of specialty care services (beyond the initial 5 identified by government); and (2) the total wait times that patients face in trying to access specialty care. We urge governments to take the necessary steps so that they can begin collecting and reporting on total wait times for a broad array of medical services.

The WTA plans to expand its assessment of Canadians' access to a broader range of specialty care in future report cards.

Reference

1. The Canadian Association of Emergency Physicians' (CAEP) Position Statement on Emergency Department Overcrowding (February 2007) for more information on the CTAS guidelines.
See: www.caep.ca/CMS/get_file.asp?id=c3a68d63aa5c462e9689c17175f7c6ba&ext=.pdf&name=CAEP_ED_Overcrowding.pdf

About the Wait Time Alliance

Since 2005, the Wait Time Alliance (WTA) has been issuing reports on Canadians' access to timely specialty care. The WTA is comprised of 13 associations and brings together several national medical specialty societies whose members are directly involved in providing care to patients. The WTA members are (in alphabetical order):

- Canadian Anesthesiologists' Society (CAS)
- Canadian Association of Emergency Physicians (CAEP)
- Canadian Association of Gastroenterology (CAG)
- Canadian Association of Nuclear Medicine (CANM)
- Canadian Association of Radiation Oncology (CARO)
- Canadian Association of Radiologists (CAR)
- Canadian Cardiovascular Society (CCS)
- Canadian Medical Association (CMA)
- Canadian Ophthalmological Society (COS)
- Canadian Orthopaedic Association (COA)
- Canadian Psychiatric Association (CPA)
- Canadian Society of Plastic Surgeons (CSPS)
- Society of Obstetricians and Gynaecologists of Canada (SOGC)