
THE TAMING OF THE QUEUE: TOWARD A CURE FOR HEALTH CARE WAIT TIMES

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The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 57,000 members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.



Founded in 1908, the Canadian Nurses Association (CNA) is the national professional voice for over 120,000 registered nurses in Canada. CNA is a federation of 11 provincial and territorial nursing colleges and associations whose mission is to advance the quality of nursing in the interest of the public.

CONTENTS

Acknowledgements	iv
Executive Summary	v
Introduction	1
1. Framing the issues and sizing up the problem	2
The waiting time phenomenon in health care systems	2
How long is too long?	4
Sizing up the problem	5
Public and physician perception of wait times	6
Pan-Canadian performance indicators	7
2. Strategies for managing wait times and ensuring timely access	9
Overview of provincial initiatives	9
Western Canada Waiting List Project (WCWLP)	11
Other wait-time initiatives	12
3. People and tools: ensuring adequate system capacity	13
The relation between health system capacity and wait times	14
Looking back at the Canadian experience in the 1990s	15
Optimizing existing capacity while planning for a sustainable health system	16
4. Entitlement to timely care: where to draw the line	17
What does existing federal and provincial legislation say about timely access?	17
Is there a Charter right to timely health care?	18
Standards for timely access — what is achievable?	19
5. Policy implications of improved wait-time measurement, monitoring and management	21
Appendix A: Operational principles for the measurement and management of wait lists	24
Appendix B: Provincial wait-time initiatives	26
Glossary	30
References	32

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Executive Summary

I FRAMING THE ISSUES AND SIZING UP THE PROBLEM

Waiting for care is part and parcel of the normal functioning of any health system. Where scarcity exists, rationing demand for services is a given. No country could sufficiently resource its health system so as to meet all urgent demands for health care. Even in the United States, where significant private funding exists, waiting for care is still the reality for millions of uninsured Americans.

Although waiting for care is a fact of life, excessive waiting can engender significant health and economic impacts. Health professionals also experience adverse effects of long waits for service, including a growing frustration associated with the inability to provide timely and appropriate health care. A common understanding of appropriate versus excessive waiting is critical in a publicly funded system with constrained capacity and competing demands for resources. Without this, it is impossible to prioritize patients according to relative health need, nor determine whether or not the system is adequately resourced to provide timely care.

Wait times are currently measured in a number of ways including surveys of physicians and patients, analysis of administrative data, hospital booking systems, registries and priority scoring systems. Each of these methods has inherent advantages and limitations that are well documented. In recent years, physician and patient surveys have been the main source of information to gauge wait times. While these surveys do not have the rigour of administrative databases with standardized collection of data, they provide key information with respect to the performance of the health system a propos timely delivery of health services. For example, in a recent survey conducted by Ipsos-Reid on behalf of the Canadian Medical Association, the top four health care concerns reported by Canadians were: long wait times for specialists; the shortage of health care professionals across Canada; long wait times for emergency room services; and long wait times for diagnostic services.

In September 2000, the First Ministers agreed to provide clear reporting to Canadians on health system performance, beginning in September 2002. Common indicators were developed for 14 areas with respect to health status, health outcomes and quality of health care services. “Waiting times for key diagnostic and treatment services” is one of the categories listed under the broader theme of quality of health services. This category was further subdivided into three treatment areas: cardiac surgery, hip and knee replacement and radiation therapy. For each treatment area, jurisdictions have agreed to report on time to clear the wait list, median wait times and the distribution of wait times. Unfortunately, due to the lack of detailed reporting, proper inter-provincial comparisons were not possible for the first round of public reporting.

II STRATEGIES TO MANAGE WAIT TIMES AND ENSURE TIMELY ACCESS

There has been a great deal of activity across Canada in recent years as provinces have stepped up efforts to manage waiting times. There are currently wait-time management initiatives underway in seven provinces.

In British Columbia, the Ministry of Health Services maintains a surgical wait-list registry to track wait times for a variety of surgical procedures. Similar online wait-list registries have been established in Alberta, Manitoba and Quebec. Surgeons and health professionals in selected hospitals share information on their wait times for surgeries and diagnostic tests to enable patients and their providers to plan where to best access these services. The number of procedures monitored varies depending on the province, as does the frequency with which the Web sites are updated.

The Saskatchewan Surgical Care Network has been working with key health partners to improve the system's effectiveness, organization and efficiency so that those who require surgery receive it within appropriate time frames. A province-wide, computerized surgical patient waiting list is pending. In Ontario, the Cardiac Care Network is one of the best examples of partnerships among government, physicians and hospitals for the purposes of planning, coordinating and monitoring the timely provision of services. The CCN patient registry is widely recognized as an effective way to facilitate and monitor access to cardiac surgery.

In Nova Scotia, the Provincial Wait Time Monitoring Project is working to capture meaningful, reliable provincial information on wait times that is standardized and monitored on an ongoing basis. A project committee was struck to make specific recommendations to government focusing on surgical services, diagnostic services and referrals from general practitioners to specialists.

The development of priority scoring systems to help clinicians determine relative need is an important component of wait time management strategies. The Western Canada Waiting List Project (WCWLP), a partnership of governments, regional health authorities and medical providers, has been instrumental in this regard. Phase 1 of the WCWLP developed priority-setting tools to assist in the management of waiting lists for five procedures: hip/knee replacement, general surgery, cataract surgery, MRI and children's mental health. Key deliverables of Phase 2 include implementation and evaluation of wait-list management tools, development of standardized maximum acceptable waiting times, and adaptation of the WCWLP tools for use by primary care providers. The WCWLP is one of Canada's best examples of multi-dimensional, current, end-to-end approaches to improving the quality management of waiting times in Canada.

On March 31-April 1, 2004, Canadian Policy Research Networks hosted the Taming of the Queue: Wait Time Measurement, Monitoring and Management. This colloquium was sponsored by the CMA, the Canadian Institute for Health Information, the Canadian Institutes of Health Research, and the Association of Canadian Academic Healthcare Organizations and was attended by representatives of research and academic institutions, health care providers and government officials. Objectives of the colloquium were three-fold: to explore the underlying factors that drive waiting times for health services; to share research and experiences with wait time measurement, monitoring and management among a broad cross-section of stakeholders; and to identify the policy implications of improved wait time measurement, monitoring and management from the perspective of payers, providers and patients. Over 80 participants spent two days reviewing Canadian and international initiatives and discussing what needs to happen next in Canada to move toward better measurement, monitoring and management of wait times.

III PEOPLE AND TOOLS: ENSURING ADEQUATE SYSTEM CAPACITY

Health planning for the needs of a very diverse population is not an exact science. An “adequate” supply of nurses, physicians, hospital beds and high-tech equipment cannot be determined based on any mathematical formula. Certain jurisdictions spend less on health care and have lower system capacity than others, yet they are able to achieve good health outcomes. On the other hand, there are those who spend sizeable portions of their budget on health care, have higher system capacity, and report poor health outcomes. Though the relationship between health care resources and health outcomes seems puzzling, there is no doubt that the availability of resources does come to bear on the timeliness and accessibility of health care services.

In the 1990s, Canadians experienced a great deal of flux in their health system. While Canada ended the decade precisely where it began with respect to physician resources, all other G7 countries increased their physician to population ratio. In terms of acute-care capacity, G7 countries experienced a decline in the number of beds per 1,000 population, reflecting a continuing trend towards decreasing lengths of stay, increasing use of day surgery, and a shift from hospitals to community-based health service delivery. Canada ended the decade with a bed capacity significantly below that of its major trading partners. With respect to tools and equipment, the gap between Canada and other G7 countries widened significantly. As an illustration of this, Canada’s capacity in the area of MRI was about one-third the average of the G7 countries in 1990, and despite more than tripling the number of units over the decade, Canada remained at about one-third the G7 average in 2000. Finally, in the category of average investment in capital over the 1990s as a share of total health expenditures, Canada has again fallen short of the average level of capital investment in G7 countries.

Regardless of new or additional capacity, Canada can gain markedly from improving the quality of management of existing resources. Needs-based planning for the provision of evidence-based care and sustainable resourcing are the key elements in planning long term solutions to waiting time problems. Ad hoc resource augmentation to buy solutions for waiting for specific services has not proven to be an effective strategy. Long term sustainable funding must be earmarked for reducing wait lists in order to allow for appropriate planning.

IV ENTITLEMENTS TO TIMELY CARE: WHERE TO DRAW THE LINE?

The Canada Health Act purports to “...to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” There is some public expectation that the content of reasonable access addresses the notion of timely access. As the concept is defined, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health care services at the setting where the services are provided and as the services are available in that setting.

The question of whether a right to timely care under the Canadian Charter of Rights and Freedoms exists has been the subject of recent research. To date, no court has ruled that a positive obligation exists on the part of governments to ensure timely access to publicly- funded health services.

The Supreme Court of Canada's decision to hear an appeal with respect to accessing publicly funded services (*Chaoulli and Zeliotis v Quebec*) underscores the fact that timely access to care is increasingly viewed as a right of citizenship.

Across the country, there have been increasing calls to formalize rights to timely care through the adoption of patient charters and health care guarantees. At the national level, development of care guarantees based on evidence-based benchmarks for timely access to care has been proposed by the Senate Standing Committee on Social Affairs, Science and Technology and the CMA. The Commission on the Future of Health Care in Canada chaired by Roy Romanow has recommended a health covenant to set out patient responsibilities and entitlements. Thus far, there have been no commitments by governments to act on such proposals. Proposals for health/patient charters have been advanced in a number of provinces. Some remain electoral promises, while others have reached the stage of draft legislation. A recent OECD study and the CMA's four-country study of stakeholder perspectives suggest a note of caution with respect to the adoption of care guarantees.

No matter which policy approach is adopted, the key gap that remains is the determination of publicly and clinically acceptable waiting times for procedures and patients with varying degrees of urgency. Only then can the question of precise form and enforceability of standards of timely care be addressed.

V POLICY IMPLICATIONS OF IMPROVED WAIT TIME MEASUREMENT, MONITORING AND MANAGEMENT

The question of how to provide timely access to health care in Canada will not be resolved overnight. While there have been a number of promising developments concerning the management of wait times for surgery and diagnostic procedures, there is also the reality of limited system capacity and the prospect of court-imposed solutions.

The following ten-point plan would contribute to an orderly and effective response to managing wait times in Canada:

1. Set priorities through broad consultation

With input from health care providers and the public, prioritize conditions or services that will be addressed, beginning with those of most clinical importance that are known to have long waits and gradually expanding the scope to include all services.

2. Address patient/public expectations through transparent communications

Inform patients and the public about the role that waiting lists and wait times play in the management of health services. Ensure transparency and improve confidence in the health system by informing patients how long they have to wait and how their priority is being determined with respect to other patients on the list.

3. Address immediate gaps in health human resources and system capacity

Commit to aggressive recruitment and retention strategies to fill gaps where scarcity of health human resources is the driving factor behind excessive wait times. Adopt a policy of increased self-sufficiency in the production of health professionals in Canada.

Develop a needs-based planning framework to ensure that longer-term investments in physical and human resource capacity are made where they are most needed.

4. Improve data collection through investments in information systems

Continue to develop prospective data collection systems at the provincial level using standardized data definitions. Combine wait-time data held by individual health professionals and/or institutions, into a more efficient and centralized booking system, so as to serve a group of health professionals and/or institutions. Work with Canada Health Infoway Inc. to expand the use of information technology as a resource to improve coordination across health care providers and institutions.

5. Develop wait time benchmarks through clinical and public consensus

Establish benchmarks that incorporate clinical criteria and public preferences. To accelerate development of priority-setting tools and benchmarks for timely access across a full range of treatments, the federal government could build on the success of the Western Canada Waiting List Project and create centres of excellence in wait-time management with nodes across the country.

6. Strengthen accountability by way of public reporting

Publicly report on waiting times in a meaningful fashion. At the national level, commit to enhanced public reporting of inter-provincial comparisons of wait times through the Canadian Institute for Health Information and the Health Council of Canada. Expand the use of online wait-list registries to provide up-to-date information on waiting times across regions and institutions.

7. Maximize efficiencies by aligning incentives properly

Increase inter-provincial collaboration to share capacity and develop centres of excellence for highly specialized care, supported by pan-Canadian referral networks. Reform hospital funding by moving toward activity-based funding to ensure that service provision is not artificially constrained by budget caps and can expand or contract as needed. Ensure that physicians are aware of clinical practice guidelines.

8. Address upstream and downstream pressures by investing in the continuum of care

Address pressure points in other related areas of the health care system by taking a “whole system” approach. Support the development of disease-management strategies at the regional

health authority level to provide for coordinated service delivery across prevention, primary care, acute care, home care, rehabilitation and long-term care.

9. Expand inter-jurisdictional care options by enhancing portability provisions

Enhance options available to patients when timely care is not available locally. Revisit in-country and out-of country portability provisions under the *Canada Health Act*, interprovincial reciprocal billing agreements and provincial health insurance legislation to streamline the process whereby patients may seek care in another jurisdiction when timely care is not available in their province of residence. Create a federal-provincial cost-shared Canada Health Access Fund to better support patients and their families that receive care outside their jurisdiction.

10. Commit to adoption of best practices through enhanced research and evaluation

Commit to a rigorous program of ongoing research and evaluation through the Canadian Institutes of Health Research, the Canadian Health Services Research Foundation and other granting bodies. Learn from success stories and best practices. As data become increasingly robust for individual services, expand research to include the prioritization of patients across services.

Managing wait times in Canada poses a systemic challenge which will not be resolved in the short term. Policy regarding wait time measurement, monitoring and management is evolving, and as such, each of the above-mentioned directives will be examined in greater detail in the coming months.

Introduction

Central to Canada's system of universal, publicly funded health insurance is the notion that people should have access to health services at the time and to the extent of need², without financial or other barriers. With the introduction of universal hospital and medical insurance in the 1960s and 1970s, Canada made great strides toward eliminating financial barriers to medical and hospital care. However, ensuring accessible health services infers much more than the absence of financial barriers.

The past 15 years have marked one of the most tumultuous periods in the history of Canadian health care policy, starting with fiscal restraint and retrenchment in the early 1990s, followed by increasing intergovernmental discord and growing public disenchantment. Patients have found it increasingly difficult to find a family physician¹. Hospital emergency wards have become overcrowded and, in some jurisdictions, waiting lists for specialist consultations, advanced diagnostic services and acute care services have been getting longer. Many of these issues have received significant media attention. Recently, reinvestments and a climate of renewed cooperation have provided some reason for optimism; however, public confidence in the health system has not yet fully recovered.

Concern about wait times for health services is not unique to Canada, indeed concern is common among many industrialized countries. International experience with wait-time management is full of valuable lessons for health care providers and policymakers in Canada. The Organisation for Economic Co-operation and Development (OECD) recently published a groundbreaking study of wait-list management strategies in its member countries³. As well, the CMA has just completed a four-country study of stakeholder perspectives on wait-time management in Australia, New Zealand, Sweden and the United Kingdom⁴.

Canada has a rich, but relatively recent experience with wait-time measurement, monitoring and management. This discussion paper provides an overview of developments over the past 15 years. Section 1 sets out a framework and reports on what is currently known about the state of wait times in Canada's health system. Strategies for measuring, monitoring and managing wait times are reviewed in Section 2. Issues surrounding the adequacy of human and physical resources are examined in Section 3. In Section 4, the desirability and practicality of moving toward entitlements to timely care are explored. Finally, Section 5 draws out the policy implications of improved wait-time management for patients, health care providers and institutions, and governments.

1. Framing the issues and sizing up the problem

“Health care providers, regional health authorities and hospitals are trying to keep pace with growing demands. More surgeries, treatments and tests are being performed, but demands often outstrip their ability to deliver the necessary services on a timely basis.”⁵

Roy Romanow

The waiting time phenomenon in health care systems

Health care systems are among the most complex forms of organization in modern societies. Across all industrialized countries, health services account for a significant and growing share of total economic activity. An elaborate network of independent practitioners, community clinics, hospitals, long-term care facilities, laboratories, pharmacies, suppliers of pharmaceutical products and medical devices is called into action every time a patient presents with a health problem.

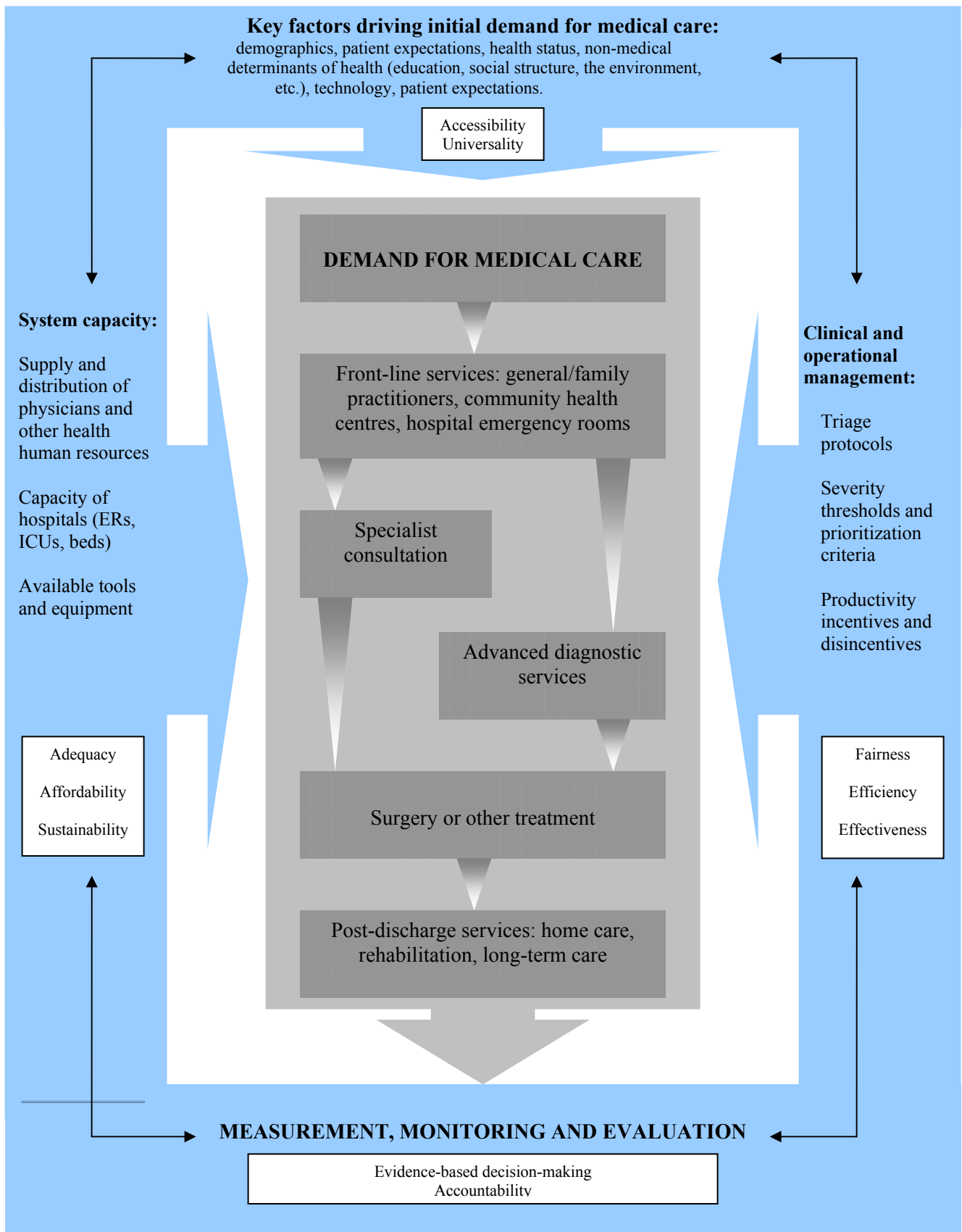
Waiting for care is part of the normal functioning of any health care system. Scarcity relative to limitless wants and needs is a given. No country has sufficient resources at its disposal to build the excess capacity necessary to meet all health care needs, irrespective of clinical urgency, on an urgent basis. Even in health care systems with significant privately funded capacity, waiting for health care is a reality in a world dominated by health care maintenance organizations. In the United States, for example, an estimated 45 million people are underserved or uninsured.

In certain cases, waiting for health care can be the best option for a patient, depending on the individual’s symptoms and ability to function. The age-old practice of “watchful waiting” stems from the observation that, for many patients, the best course of action is to wait and see how their condition evolves. Sometimes, the problem resolves itself; other times, the need for medical intervention becomes clearer and more pressing.

Wait times are not homogeneous; they vary across the country and by service or procedure. Furthermore, their distribution varies widely — not everyone waits for a long time for a particular procedure. A complex interplay of demand, supply and productivity or efficiency factors contribute to wait times. Given the limited availability of comparable wait-time data, it is difficult to document perceptions versus reality.

Figure 1 illustrates the chain of decisions involved in providing medical care to patients and the many policy objectives and factors that come into play to determine wait times at various points in the system. At the top is the pool of potential patients that may enter the system at any time. This initial demand for health care services is governed by the principles of universality and accessibility and depends on many factors, including non-medical determinants of health, demographics, changing technology, the emergence of new disease patterns and patient expectations.

Figure 1: Framework for the provision of medical care



The key service points in the health care system — front-line services, specialists, advanced diagnostic services, surgery and other treatment and post-discharge services — are connected by a series of decision protocols or sieves that determine which patients go on to the next level and in what order. At the base of the diagram are the key functions — measurement, monitoring and evaluation — that provide the evidence base for decisions around system capacity and its management.

At each of the service points in the chain, a number of system capacity and management-related factors interact. Capacity refers to the health human resources, equipment and physical infrastructure necessary to deliver health care; these are fixed at any particular time. Decisions about system capacity are based on considerations of adequacy, affordability and sustainability. Management factors comprise clinical and administrative practices that have a bearing on how the existing system capacity is used, including clinical decision-making, resource coordination and allocation, and performance incentives and disincentives. Key policy objectives in this domain include fairness, efficiency and effectiveness. All of these factors are constantly evolving and their interactions determine how long patients must wait to pass through the sieve at each level of the system.

How long is too long?

Waiting for care is part and parcel of the normal health care experience; yet there is a point beyond which waiting — as has been shown for coronary artery bypass grafting⁶ and for hip replacement surgery⁷ — becomes excessive and potentially harmful to the patient's health and well-being⁸. Excessive waiting for health care can result in significant health and economic impacts. Adverse health impacts include poorer post-operative outcomes (including the possibility of death) and decreased quality of life during the waiting. Economic impacts include increased health expenditures before and after surgery, increased prescription drug costs to manage the condition during the wait, loss of personal income and/or increased public expenditure on income support, and loss in societal capacity. Health professionals too, experience adverse effects of long waits for service, including growing frustration of not being able to provide the quality of care they know is appropriate⁹.

Developing a common understanding of appropriate versus excessive waiting times is critical in a publicly funded system with constrained capacity and many competing demands on resources. Patients clearly filter the notion of acceptable waits as a result of personal experiences; clinicians gauge waits by their clinical experience and available literature or practice guidelines; governments tend to judge waiting times on the basis of cost and competing demands for public resources¹⁰. Without a common understanding, it is impossible to ensure that the system is treating patients according to their relative health need, nor is it possible to determine whether the system has adequate resources to provide timely care.

In some key areas such as cardiac care and radiation therapy, reaching a consensus among clinicians on severity thresholds has proved to be relatively straightforward because the consequences of not providing timely care can be catastrophic. Cardiac surgery is further blessed by objective, quantifiable data, such as the percent of vessel stenosis, by which to classify patients¹¹. In other areas, such as orthopedic surgery, where the consequences of delayed intervention are more often associated with decreased quality of life — a subjective factor — than with death, a common understanding of excessive waiting has proved to be more elusive.

Moreover, there are other perspectives on appropriate versus excessive wait times that matter. Patients and their families, who must ultimately bear the consequences of waiting, may feel that treatment should be provided much more rapidly than clinical consensus indicates. Employers concerned about losing productive workers may also want more urgent treatment for their employees. Administrators responsible for allocating health resources may be inclined to focus resources on emergency services and consequently increasing waits for elective surgeries. Collectively, taxpayers concerned with the rising cost of health care services may be willing to tolerate longer waits within the health system as a means of avoiding tax increases, provided that they themselves are not affected.

Fundamentally, it is a question of perspective and values. Despite these many challenges, progress has been made toward increasing transparency and accountability in waiting processes. The vocabulary of waiting is now better understood. Priority is equated with urgency, a term signifying severity in addition to considerations of expected benefit and the natural history of the disease¹². Methods have been developed to create priority scoring systems for a number of clinical conditions by incorporating expert opinion, evidence from the literature and public opinion¹³.

Sizing up the problem

Wait times can be measured in a number of ways: surveys of physicians and patients, analysis of administrative data, hospital booking systems, registries and priority scoring systems. Each of these approaches has inherent advantages and limitations that are well documented¹⁴.

Surveys often provide a useful snapshot of patient and physician perceptions, but are subject to response bias depending on the questions asked, when they are asked (i.e., recall problems), sample size and response rate. Analysis of administrative data generated by hospital and physician billing claims is relatively inexpensive, but only useful to monitor waits for procedures that are recorded. Hospital booking systems can track the length of waits for specific procedures within an institution, but generally do not provide information on relative urgency and priority of patients. Central registries and priority scoring systems, such as the Ontario Cardiac Care Network, provide for more rigorous measurement and reporting of wait times, but are more costly to develop and maintain.

Physician and patient surveys continue to be the main source of information available to gauge wait times. Several provinces have invested in centralized registries and performance reporting has improved at the provincial and national levels, but thus far there are few hard data available to provide an objective assessment of wait times.

Public and physician perception of wait times

Surveys of patients and physicians have been used since the early 1990s to track perceptions and attitudes about wait times in Canada. Although these approaches do not have the rigour of administrative databases with standardized collection of data, they still provide an important window on performance of the health system in ensuring the timely delivery of services. Key contributions include the following:

- Between 1989 and 2001, the *Berger Health Monitor* found that the proportion of Canadians who reported that they were unable to obtain needed health care services increased from 2% to 15%¹⁵.
- The CMA has included questions about waiting times for health care in a number of public opinion surveys. Over the last 3 years, the CMA's annual report on health has found that, despite improvements in some parts of the system, Canadians continue to rate access to specialists and diagnostic equipment poorly¹⁶.
- In a recent survey conducted by Ipsos-Reid on behalf of the CMA, the top four health care concerns reported by Canadians were: long wait times for specialists, the shortage of health care professionals across Canada, long wait times for emergency room services and long wait times for diagnostic services⁴. Two-thirds of Canadians indicated that they or a member of their family had to wait longer than they thought reasonable for medical services in the last year, and 48% of those reporting unreasonable waits saw their condition worsen or their stress and anxiety increase as a result. Examples of adverse health impacts cited by those reporting unreasonable waits include increased pain (12%), condition deterioration (7%) and death (2%).
- Since 1993, the Fraser Institute has been publishing an annual report on waiting lists for hospital care. These reports are based on a survey of physicians who offer opinions about the amount of time a new patient can expect to wait for a range of surgical and diagnostic procedures. The survey has reported significant year-over-year increases in physician perceptions of waiting times since the early 1990s and has claimed that in the vast majority of specialties, actual waits exceed what physicians indicate to be clinically reasonable¹⁷.
- British Columbia undertook two waiting-list studies in 1998 based on a survey of specialists in British Columbia. The first, a British Columbia Medical Association report, looked at waiting times for cardiac, orthopedic, ophthalmology, and diagnostic services¹⁸. The second report issued by the BC Ministry of Health and Ministry Responsible for Seniors focused on emergency medicine, neurosurgery, general surgery and diagnostics¹⁹. Both studies found that median waits across most of these specialties were significantly higher than what physicians consider reasonable.

In 2001, Statistics Canada conducted the first national survey on access to health care²⁰. This survey probed the experience of respondents needing specialist care, non-emergency surgery and diagnostic tests. Questions on their experiences covered information such as waiting time to obtain the service, acceptability of the waiting time and impact of the wait on the respondent. Data from this survey were used to populate provincial reports on health system performance (see below).

A second iteration of this survey was conducted in 2003, with results released by Statistics Canada in June 2004²¹. Key findings include the following:

- Among those who had sought first contact services, 16% had experienced difficulty accessing routine care and health information, and 24% had experienced difficulty accessing immediate care for a minor health problem.
- Difficulties in getting access to specialized services were reported by 21% of those who accessed specialist visits, 13% of those who had non-emergency surgery, and 16% of those who accessed diagnostic tests.
- Although most patients waited three months or less to access specialized services, some 17% waited longer than 3 months (the provincial rate varied from 10% in Newfoundland to 29% in Saskatchewan).
- Waits exceeding 3 months were experienced by 13% of those waiting for cardiac and cancer-related surgery, 26% of those waiting for joint replacement and cataract surgery, and 16% of those waiting for other non-emergency surgeries.
- The percentage of patients who considered their wait time unacceptable was 17% for non-emergency surgery, 21% for diagnostic tests and 29% for specialist visits, with large interprovincial variations in all three areas.
- The proportion of people that said waiting affected their personal lives ranged from 10% for non-emergency surgery, 14% for diagnostic tests and 19% for specialist visits.

Pan-Canadian performance indicators

In September 2000, Canada's first ministers issued a communiqué on health in which they agreed to provide clear reporting to Canadians, beginning in September 2002²². Health ministers established a federal-provincial-territorial (FPT) committee, the Performance Indicators Reporting Committee (PIRC), to achieve agreement on comparable reporting by all FPT jurisdictions in 14 areas identified by the first ministers. Each jurisdiction is responsible for publishing a separate report containing information on these areas.

Common indicators have been developed for 14 areas of health status, health outcomes and quality of health care services; “waiting times for key diagnostic and treatment services” is one category under the quality of health care services theme. This category was subdivided into three treatment areas, namely cardiac surgery, hip and knee replacement surgery, and radiation therapy. For each treatment area, jurisdictions have agreed to report on time to clear the wait list, median wait times and the distribution of wait times.

The first provincial and federal health system performance reports were delivered, as promised, in September 2002. Although the quality and comprehensiveness of reporting was high in most other areas, the table below shows that reporting on wait-time indicators was generally cryptic or absent, except for cardiac care. The lack of detailed reporting does not allow for proper interprovincial comparisons. Furthermore, to compensate for the lack of hard data on wait times for specialists, diagnostic tests and surgeries, provinces used wait times reported by Statistics Canada’s *Health Services Access Survey*. Pursuant to the February 2003 health accord, an expanded set of indicators is being developed for the next round of federal and provincial performance reports, scheduled for release in September 2004²³.

Table 1: Provincial reporting on wait-time indicators

	BC	AB	SK	MB	ON	QU	NB	NS	PEI	NF
Waiting times for cardiac surgery										
<i>Time to clear</i>	++	++	-	++	++	-	++	++	-	++
<i>Median wait time</i>	++	-	++	++	++	-	++	++	-	++
<i>Distribution</i>	++	-	++	++	++	-	++	++	-	++
Waiting times for total hip and knee replacement surgery										
<i>Time to clear</i>	++	++	-	++	-	-	-	-	-	-
<i>Median wait time</i>	++	++	++	++	-	-	-	-	-	-
<i>Distribution</i>	++	-	++	++	-	-	-	-	-	-
Waiting for radiation therapy										
<i>Weeks to clear</i>	++	++	-	++	-	-	-	++	-	++
<i>Median wait times</i>	-	-	-	++	-	-	-	++	-	++
<i>Distribution</i>	-	-	-	-	-	-	-	-	-	-
Reported wait times for specialist physician visits, certain diagnostic tests and non-emergency surgery										
<i>Reported median wait time</i>	+	+	+	-	-	-	-	-	+	+
<i>Distribution</i>	+	+	+	-	-	+	-	-	+	+

Legend

Provincially Reported Data	++
Statistics Canada Health Services Access Survey Data	+
No Data Collected / Available	-

2. Strategies for managing wait times and ensuring timely access

“With rare exceptions, waiting lists in Canada, as in most countries, are non-standardized, capriciously organized, poorly monitored, and (according to most informed observers) in grave need of retooling.... There is consequently an urgent need for a national investment in the design and development of information and management systems that can provide the public with a greater sense of confidence about access to, and quality of care.”²⁴

P. McDonald, S. Shortt, C. Sanmartin, et. al.

This was the bleak assessment of wait-time management in Canada from a landmark study commissioned by Health Canada in the late 1990s. In 1999, the CMA issued its own policy on *Operational principles for the measurement and management of wait lists* to provide guidance on how best to address these weaknesses (Appendix A).

Has anything changed? In this section, we review the key developments across Canada in the measurement, monitoring and management of waiting times.

Overview of provincial initiatives

British Columbia — The Ministry of Health Services maintains the Surgical Wait List Registry to track wait times for a wide variety of surgical procedures at British Columbia hospitals²⁵. Cancer services and heart surgery are monitored in separate registries. Wait times for specialized hospital-based surgeries and services in 19 different categories are tracked, monitored and updated monthly. Information in the Surgical Wait List Registry comes directly from participating hospitals. The accuracy and currency of the registry is entirely dependent on the data submitted by hospitals. Some hospitals are in the midst of changing their computer systems, resulting in a lag in their wait-time reporting. As those hospitals complete their computer upgrades and more hospitals participate in the government’s registry, the database will be expanded.

Alberta — In the summer of 2003, an online wait-list registry was launched to divulge wait times for surgeries and diagnostic tests performed by specific surgeons and health professionals in certain Alberta hospitals²⁶. The registry is intended for use by patients and their physicians to plan where to best obtain surgical and diagnostic services. The Alberta Ministry of Health and Wellness also uses the registry to monitor wait times for a wide variety of surgeries and diagnostic tests at participating Alberta hospitals. All regions are expected to come online during 2004.

Saskatchewan — Formed in March 2002, the Saskatchewan Surgical Care Network (SSCN) has been working with key health partners to improve the health system’s effectiveness, organization and efficiency so that those who require surgery receive it within appropriate time frames. SSCN is overseeing the development and implementation of a province-wide computerized surgical patient waiting list²⁷.

Regional health authorities, physicians and Saskatchewan Health will use information from this registry to make decisions regarding wait-time issues and capacity requirements.

Manitoba — The Manitoba Wait Time Reduction Plan evolved as the result of a 1998 report released by the Manitoba Centre for Health Policy²⁸. The Health Services Wait Time Information Web site provides information about the length of time one might expect to wait to receive diagnostic tests at Manitoba hospitals or radiation therapy at CancerCare Manitoba. Wait-time information for other diagnostic procedures will be added in the future. A second initiative, the Manitoba Cataract Waiting List Program, uses a centralized database to track and prioritize all patients waiting for cataract surgery²⁹.

Ontario — Created in 1990, the Cardiac Care Network (CCN) of Ontario is one of the earliest and best Canadian examples of a partnership among government, physicians and hospitals for planning, coordinating and monitoring the timely provision of services³⁰. The CCN patient registry is widely recognized as an effective way to facilitate and monitor access to cardiac surgery. As a result of this success, expansion of the registry began in 2000 to include cath-lab procedures (cardiac catheterization, angioplasty, stenting). Public reporting on access to cath-lab procedures began in May 2002. The cath-lab data will be monitored and studied, like the surgical data, to help patients receive timely, equitable and appropriate access to these services.

Quebec — Before the implementation of a computerized program to monitor and track waiting times, each hospital in Quebec maintained a unique wait list; considerable variation existed in surgical wait times within the various institutions. Wait times are now posted online³¹. (Cardiac surgery wait times are posted separately and are monitored by the Réseau québécois de cardiologie tertiaire.) Significant financial investment has been dedicated to achieving reduced waiting lists and waiting periods. With the application of new data collection and management tools, the intention is to update monthly the waiting lists for the various surgical procedures being carried out in Quebec's health care institutions.

Nova Scotia — In order to capture meaningful, reliable provincial information on wait times, a plan was developed to standardize the collection and monitoring of wait times in Nova Scotia. As a result, the Provincial Wait Time Monitoring Project Steering Committee was formed to make specific recommendations to government focusing on three main areas: surgical services, diagnostic services and referrals from general practitioners to specialists³². Among its recommendations are that orthopedic wait times must be collected across the province, not only in the Capital Health District. The committee has also recommended that wait times for computed tomography and magnetic resonance imaging (MRI) be integrated into a roll-out of the Nova Scotia Health Information System, expected to be up and running in 2005.

Appendix B provides detailed information on provincial wait-times initiatives, including the procedures that are monitored, data collection and standards, priority-setting criteria and tools, funding of initiatives/capacity and online accessibility of information. Table 2 summarizes this information. It is clear that although some provinces have not yet begun to address wait-time management, a number have made remarkable progress establishing objective priority scoring tools, developing wait-time targets and making this information available electronically. There is a clear trend toward adoption of priority scoring tools in the western provinces.

This is in large part owing to the work of the Western Canada Waiting List Project. Nova Scotia is planning to adopt priority-scoring tools in 2004. Waiting-time targets have been established or will soon be established in five provinces: two western, two central and one maritime province. Three provinces have created or will create an external advisory body to provide oversight to their initiatives. Online registries are a feature in jurisdictions that have implemented initiatives to manage, monitor or measure wait times.

Table 2: Summary of provincial wait-time initiatives

Province	Monitored procedures	Priority scoring tools	Wait-time targets	External advisory body	Online registry
Newfoundland and Labrador					
Prince Edward Island					
Nova Scotia	3	✓*	✓*	✓	✓*
New Brunswick					
Quebec	9+		✓		✓
Ontario	2	✓	✓	✓	✓
Manitoba	7	✓			✓
Saskatchewan	10	✓	✓	✓	✓
Alberta	17	✓	✓		✓
British Columbia	19		✓		✓

* In progress.

More detailed information available in Appendix B.

Western Canada Waiting List Project (WCWLP)

The WCWLP, which was established in November 1998, is a collaborative effort of 20 partners: four medical associations, four provincial ministries of health and Health Canada, seven regional health authorities and four health research centres³³. It is unique in the multidisciplinary nature of its make-up and in the scope of the work it has undertaken.

Phase 1 of the project set out to address significant information gaps in the health care system and improve the fairness of the system so that Canadians have reasonable access to appropriate and effective medical services. To achieve these goals, the WCWLP partnership developed priority-setting tools meant to be valid, reliable, practical and clinically transparent to assist in the management of waiting lists for a clearly defined list of procedures and interventions. The five clinical areas the WCWLP focused on are cataract surgery, general surgical procedures, hip and knee replacement, MRI and children's mental health.

These were chosen because they represent a range of procedural, diagnostic and consultative interventions, permitting a comprehensive evaluation of priority-setting waiting list issues across a broad range of cases.

After establishing an effective partnership, the next step was to develop the priority criteria tools based on urgency. This was followed by selection of criteria items with weights that the partners would use in establishing priorities for waiting lists. Panels of clinicians were established to recommend criteria and weights and to ensure the reliability and validity of the final tool from a patient and clinician perspective. Once tools and measurement criteria were established, the

WCWLP began its pilot testing and validity work. Later stages included reliability testing, refinement of criteria and weights, additional tool design and assessment of the acceptability of the tools to the public and of barriers to their implementation through an environmental scan of regional health authorities.

Four of the five tools developed in this exercise — those for cataract surgery, general surgical procedures, hip and knee replacement, and children's mental health — had face validity and the prepared forms proved practical for use in real clinical settings. The MRI tool did not have the degree of robustness required and is thus being considered for reconstruction. The representatives of the regional health authorities who were consulted as part of the project were interested in continuing the development of tools to assist professional decision-making within the health authorities. As well, members of the general public who participated in WCWLP focus groups considered the tools developed to facilitate waiting-list prioritization to be an improvement to the health care system.

Developing standard approaches and tools for determining priority of patients to be served — the work performed by the WCWLP — is a necessary step toward improving the management of waiting lists, and thereby improving accessibility. However, beyond this necessary work, the WCWLP concluded that serious attention must be given to developing recommendations for maximum acceptable waiting times for patients at any level of priority.

The second phase of the project started in 2002 and is scheduled to continue through to the end of 2004. Key deliverables for this phase include implementation and evaluation of the wait-list management tools, development of standard maximum acceptable waiting times linked to WCWL tool scores, and adaptation of the WCWL tools for use by primary care providers.

The WCWLP has provided policymakers with a successful model for co-operation across professional disciplines and the lines that usually separate political jurisdictions. This type of co-operation is essential as we move forward to revitalize Canada's health care system. However, it takes considerable time and resources, even within a very focused sphere of activity. In addition, the adoption of priority scoring tools by provincial governments and regional health authorities remains uneven, suggesting that even greater efforts need to be devoted to knowledge transfer and the building of receptor capacity. Notwithstanding these impediments, this is one of Canada's best examples of a multidimensional, current, end-to-end approach to improve the management of waiting times in Canada.

Other wait-time initiatives

Although wait-time management initiatives tend to focus on elective services, there have also been developments in the management of waits for emergency services. For example, the Canadian Association of Emergency Physicians developed the Canadian Emergency Department Triage and Acuity Scale (CTAS), which is reported to be in use in about 80% of Canadian emergency departments. The CTAS has five triage levels based on the degree of urgency, and a corresponding maximum waiting time for patients assigned to each triage level³⁴. These are guidelines only; there are no enforceable minimum performance standards for emergency departments.

In addition to activities at the national and provincial level, there are pockets of innovation in wait-time management at the regional or local level. For example, APPROACH is an ongoing prospective data collection initiative in Alberta that began in January 1995³⁵. It captures the cohort of patients undergoing cardiac catheterization in the province of Alberta. Patients are followed longitudinally to determine short and long-term clinical, economic and quality-of-life outcomes. Using data in the APPROACH system database, researchers are able to study sociodemographic factors that may influence access to cardiovascular care.

A Kingston General Hospital initiative provides another good example of a local innovation³⁶. Jointly funded by the hospital and a grant from the Ontario Hospital Association's Change Foundation, this project will result in a Web site listing wait times by physician and service that will be accessible by potential patients and referring physicians. The initiative is based on the belief that physicians will supply accurate data if this leads to more efficient management of their practice. To date vascular, general and orthopedic surgery are the areas participating and a formative evaluation is nearing completion. The project will shortly move from the hospital intranet to the Internet, and the software is being readied for commercial distribution to other hospitals.

On March 31-April 1, 2004, Canadian Policy Research Networks hosted the Taming of the Queue: Wait-Time Measurement, Monitoring and Management. This colloquium, sponsored by the CMA, the Canadian Institute for Health Information, the Canadian Institutes of Health Research, and the Association of Canadian Academic Healthcare Organizations was attended by representatives of research and academic institutions, health care providers and government officials. Objectives of the colloquium were three-fold: to explore the underlying factors that drive waiting times for health services; to share research and experiences with wait-time measurement, monitoring and management among a broad cross-section of stakeholders; and to identify the policy implications of improved wait time measurement, monitoring and management from the perspective of payers, providers and patients. Over eighty participants spent two days reviewing Canadian and international initiatives and discussing what needs to happen next in Canada to move towards better measurement, monitoring and management of wait times³⁷.

Although it is beyond the scope of this paper to catalogue the full range of local and regional initiatives, it is important to emphasize the contribution that these initiatives are making toward improved wait-time management.

3. People and tools: ensuring adequate system capacity

*"In a field as dynamic as health services in which new discoveries are almost commonplace, forecasts must be tentative. Nevertheless, planning is essential in the effective provision of health services and in the budgeting for the capital and operating costs of the vast industry serving health needs. To wait for definitive answers to all existing problems however, would mean the loss of the benefits to be derived from existing knowledge."*³⁸

Emmett Hall

The relation between health system capacity and wait times

Planning for the health care needs of 31 million Canadians is a demanding but important challenge. There is no formula that dictates how many nurses, physicians, hospital beds and types of high-tech equipment are required to ensure that patients receive quality health services in a timely way. There are many moving targets, both in terms of demand — patient expectations, demographics and changing patterns of illness — and supply — changing standards of care, variations in practice patterns and models of health service delivery. To complicate matters further, information on the outcomes of many health service interventions, which ought to serve as the basis for any planning exercise, is still relatively sparse. There are examples of jurisdictions that spend relatively little on health care and have lower system capacity, but still achieve relatively good health outcomes, just as there are some that spend more and have higher system capacity yet poorer health outcomes.

Beyond the puzzling relation between health care resources and health outcomes, there can be no doubt that the availability of resources *does* have a bearing on the timeliness and accessibility of health care services. In a recent OECD paper, authors Jeremy Hurst and Luigi Siciliani examine the relation between system capacity and the magnitude of wait-time problems experienced by OECD countries³. In the countries experiencing waiting-time problems, the availability of doctors was the most significant factor associated with waiting times. The authors found that a marginal increase of 0.1 practising physicians and specialists per 1000 population was associated with a reduction in mean waiting times of 8.3 and 6.4 days respectively (at the sample mean), and a reduction of median waiting times of 7.6 and 8.9 days, across all procedures included in the study. The level of health expenditures was also found to be a significant factor; each \$100 increase in total per capita health spending was associated with a reduction in mean waiting times of 6.6 days and in median waiting times of 6.1 days.

Comparing countries with and without waiting times, the authors found that low availability of acute care beds was significantly associated with the presence of waiting times. They also found that countries with fee-for-service remuneration for specialists, as opposed to salaried remuneration, tended not to have a wait-time problem, and that activity-based funding for hospitals might also help reduce waiting times.

Looking back at the Canadian experience in the 1990s

Table 3 contrasts the availability of health care resources in 1990 and 2000 in Canada and across G-7 countries, which include France, Germany, Italy, Japan, the United Kingdom and the United States. In the area of physician resources, Canada ended the decade exactly where it began, at roughly 2.1 physicians per 1000 population. During this period, all of the other G7 countries increased their physician to population ratio, such that by 2000, the gap between Canada's physician supply and the average for G7 countries had increased from 0.4 to 0.7 physicians per 1000 population. Medical school enrolments in Canada decreased in the early 1990s, but the effect was only beginning to be felt in 2000. Although governments have now reversed these cuts, the dip in medical school output during the 1990s combined with the changing demographics and practice patterns within the medical profession will make it difficult to expand medical capacity significantly in the near future⁶⁰.

In terms of acute care capacity, G-7 countries experienced a decline in the number of beds per 1000 population, reflecting a continuing trend toward decreasing lengths of stay, increasing use of day surgery and a shift from hospitals to community-based health service delivery. Canada's ratio declined from 4 to 3.2 beds per 1000 population, compared with a drop from an average of 5.7 to 4.6 beds per 1000 population for G7 countries. In this area, the gap between Canada and the other G7 countries narrowed slightly, but Canada still ended the decade with a bed capacity significantly below that of its major trading partners. Insufficient acute and chronic care bed capacity has been identified as a significant factor in emergency department overcrowding in Canadian hospitals².

Table 3: Health system capacity in G7 countries ³⁹

G7 country	Practising physicians per 1000 population		Acute care beds per 1000 population		MRI units per 1 million population		Average annual capital investment as % of health expenditures
	1990	2000	1990	2000	1990	2000	1990-2000
Canada (rank)	2.1 (5th)	2.1 (5th)	4.0 (4th)	3.2 (5th)	0.7 (7th)	2.5 (7th)	3.1 (4th)
France	3.1	3.3	8.5	6.7	0.8	2.6	2.5
Germany	2.8	3.3	7.5	6.4	1.9	6.2	3.1
Italy	3.8	4.1	6.2	4.3	1.3	7.5	5.4
Japan	1.7	1.9	—	—	6.1	23.2	5.0
United Kingdom	1.5	2.0	—	3.9	1.0	4.6	5.2
United States	2.4	2.7	3.7	2.9	3.7	8.1	1.7
G7 average	2.5	2.8	5.7	4.6	2.2	7.8	3.7
Canada–G7 gap	-0.4	-0.7	-1.7	-1.4	-1.5	-5.3	-0.6

In terms of tools and equipment, the gap between Canada and other G7 countries widened significantly during the 1990s. As an illustration of this, Canada's capacity in the area of MRI was about one-third the average of the G7 countries in 1990, and despite more than tripling the number of units over the decade, Canada remained at about one-third the G7 average in 2000. Under both the 2000²² and the 2003²³ health accords, the federal government provided additional funding to support increased investment by provinces in diagnostic and medical equipment.

The final column in Table 3 shows the average investment in capital over the 1990s as a share of total health expenditures. This category of expenditure includes public and private investment in capital formation in health facilities. Here again, Canada has fallen short of the average for the G7 countries.

Optimizing existing capacity while planning for a sustainable health system

Irrespective of new or additional capacity, there is much to be gained from improving the quality of management of existing resources. Centralized booking systems can ensure that available capacity across a region is used as efficiently as possible. Enhanced coordination and teamwork among health care providers, aided by improved information technology, can help reduce unnecessary delays between different stages of treatment.

Clinical practice guidelines and priority-setting tools can help moderate demand for care and ensure that available resources are used appropriately. Targeted funding can also be used to increase provider productivity. Financial incentives have an important role to play in this regard. Without incentives, the health system loses the ability to send and receive signals required to align supply of and demand for health care services.

Needs-based planning for the provision of evidence-based care and sustainable resourcing are the key elements in planning long-term solutions to waiting time problems. Ad hoc resource augmentation to “solve” waiting time crises for specific services has not proved to be an effective strategy. There are many reports from the United Kingdom, Australia and the United States of resource enhancement initiatives that have failed to reduce waiting times⁴⁰⁻⁴³. To allow for proper planning, long-term sustainable funding must be earmarked for reducing wait lists.

4. Entitlement to timely care: where to draw the line

“Thus, in the Committee’s opinion, the failure to deliver timely health services in the publicly funded system, as evidenced by long waiting lists for services, is likely to lay the foundation for a successful Charter challenge to laws that prevent or impede Canadians from personally paying for medically necessary services in Canada, even if these services are included in the set of publicly insured health services.”⁴⁴

The Senate Standing Committee on Social Affairs, Science and Technology

What does existing federal and provincial legislation say about timely access?

The *Canada Health Act* sets out the five conditions — universality, comprehensiveness, accessibility, portability and public administration — that provincial and territorial health plans must meet to qualify for federal health transfers. The objective of the legislation is “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate *reasonable access* to health services without financial or other barriers” (emphasis added)⁴⁵.

The accessibility criterion of the *Canada Health Act* is intended to ensure that residents of a province or territory have *reasonable access* to insured services on uniform terms and conditions, unprecluded and unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances). The concept of “reasonable access” was, therefore, not intended to address the notion of timely access.

In terms of the physical availability of medically necessary services, “reasonable access” has been interpreted under the *Canada Health Act* using the “where and as available” rule. In other words, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health care services in the setting “where” the services are provided and “as” the services are available in that setting⁴⁵.

Each province and territory has its own health insurance legislation that sets out the broad parameters for the health insurance benefits that are available to its residents. Similar to the *Canada Health Act*, these laws contain many provisions aimed at ensuring that patients do not face financial barriers to obtaining insured health services, but there are virtually no provisions that relate to timely access. All are based on the “exclusionary” principle of social insurance; that is, all medically required services should be covered except those specifically excluded (i.e., cosmetic procedures).

Portability of benefits is one area of federal and provincial legislation that can play an important role in ensuring timely access. In principle, mechanisms should be in place to enable those who are unable to receive timely care locally to obtain services with full public coverage in another jurisdiction. Under the *Canada Health Act*, provincial and territorial health insurance plans are required to provide coverage for their residents who are temporarily absent from their home province or territory, both within and outside Canada.

To expedite claims processing on out-of-province hospital and medical benefits, provinces and territories have signed reciprocal billing arrangements. Quebec has not signed this type of agreement for out-of-province medical benefits, although it has agreements with Ontario in certain border communities.

However, the federal government's interpretation of the portability criterion is that it was intended to deal with temporary absences and emergency services not elective services outside the jurisdiction. Accordingly, most jurisdictions require prior approval by the health insurance plan for any out-of-province service other than emergency care, and these benefits are usually reserved for treatments that are simply not available (as opposed to available, but not in a timely way) in the home province or territory.

In some provinces, patients can appeal to an administrative tribunal to obtain out-of-country coverage in cases where timely care is not available locally. However, the bar has been set very high: for example, Ontario's Health Services Appeal and Review Board requires evidence that the delay would "result in death or medically significant irreversible tissue damage." In only one case to date, *Stein v. Québec*, a patient has been successful in challenging a provincial health insurance plan for having denied out-of-country coverage for a treatment that was not available in a timely way within the province⁴⁶.

Is there a Charter right to timely health care?

The question of whether there exists a right to timely care under the *Canadian Charter of Rights and Freedoms* has been studied by legal scholars⁴⁷. At issue is whether section 7 of the Charter, which guarantees the right to life, liberty and security of the person, includes a right to timely access to health services. To date, the courts have been reluctant to interpret this section of the Charter as conveying an obligation on governments to ensure timely access to publicly funded health services.

As the quote at the beginning of this section suggests, some observers believe it is only a matter of time before the courts weigh in on the debate on waiting times and access in Canada's publicly funded health system. The Supreme Court of Canada's decision to hear an appeal in the matter of *Chaoulli v. Quebec* is an interesting case in point. At issue is whether Quebec's public health insurance legislation prohibiting the purchase of private insurance for publicly-insured health services and private payment for hospital services is unconstitutional in that it violates section 7 of the Charter. To establish a violation, the court will require proof that the government has deprived a citizen of one or more of the rights, "life, liberty or security of person," protected under section 7. This deprivation must then be shown to be contrary to the principles of fundamental justice. Finally, the deprivation must not be defensible under section 1, which requires that a violation of rights is done for reasons that can be justified in a free and democratic society⁴⁸. A decision in the Chaoulli case is expected in winter 2005.

These developments underscore the fact that timely access to health care is increasingly viewed as a right of citizenship, if not in strictly legal terms, at least in the minds of the public. The stakes are indeed very high in Canada's publicly-funded health care system; if the courts rule that governments cannot prohibit patients from paying privately for timely health care, the very

foundation of medicare will be called into question. On the other hand, if governments are able to demonstrate by their actions that they are committed to ensuring an acceptable standard of timely care, then the likelihood of a successful Charter challenge diminishes.

Standards for timely access — what is achievable?

Somewhere between the status quo and the recognition of Charter rights to timely access lies a realistic policy solution to ensuring the delivery of health care within clinically acceptable standards of timeliness.

There have been a growing number of proposals for patient charters and health care guarantees across the country. At the national level, both the Senate Standing Committee on Social Affairs, Science and Technology and the CMA have called for the development of care guarantees based on evidence-based benchmarks for timely access to care⁴⁴. The Commission on the Future of Health Care in Canada⁵ chaired by Roy Romanow recommended a health covenant that would set out patient responsibilities and entitlements, similar to the CMA's proposed health charter⁴⁹, but rejected care guarantees as a viable solution. However, governments did not make any commitment to act on these proposals in the 2003 health accord²². During the 2004 federal election, the Liberal party pledged to develop reasonable and medically-appropriate wait times and set targets to reduce wait times in five areas where pressures are greatest: cancer, cardiac surgery, diagnostic imaging, joint replacements and sight restoration⁵⁰.

At the provincial level, the Alberta Premier's Advisory Council on Health chaired by Don Mazankowski, recommended a comprehensive 90-day care guarantee for a select number of services⁵¹. An expert advisory panel was struck to develop an implementation plan, but advised against the enactment of a rigid care guarantee in favour of a more flexible definition of reasonable access to timely care based on procedure-specific evidence.

Proposals for a health or patient charter have been advanced in a number of provinces, some remaining as electoral promises and others reaching the stage of draft legislation. In its 2003 election platform, the Quebec Liberal party promised to create a patients' charter of rights and responsibilities that would guarantee access to health care within medically indicated wait times. The Government of Ontario also promised to implement a patients' charter that would set out what patients have a right to expect from their health system⁵². However, neither of these proposals has been implemented. The Government of Newfoundland and Labrador made a commitment to establish a health charter and has undertaken public consultations⁵³. Legislation to create a patient charter has been introduced in New Brunswick⁵⁴ and Alberta⁵⁵, but both bills died on the order paper.

A cautionary note is sounded by the experience with guaranteed waiting times in other countries as documented in an OECD study³ and in the CMA's four-country study of stakeholder perspectives⁴. In Britain, although such an approach reduced long waits for some patients, it has failed to reduce the average waiting times of patients admitted for surgery. In both Norway and Sweden, guarantees have been abandoned. For physicians, guaranteed waiting times represent a conflict between a policy of treatment according to clinical need and treatment based simply on time spent waiting.

Moreover, to succeed, guarantees must be accompanied by incentives either to enhance service volume or to reduce demand³. The experience with guarantees in Australia and New Zealand is as yet poorly documented¹⁰.

Whatever jurisdiction is examined or approach adopted, a key gap that remains to be addressed is the determination of publicly and clinically acceptable cohort waiting times for procedures and patients with varying degrees of urgency. Canada is well positioned relative to other countries to excel in this area with the work of the Western Canada Waiting List Project, the Ontario Cardiac Care Network and other initiatives documented in this paper. Once that Rubicon is crossed, the question of the precise form and enforceability of standards of timely care will be easier to answer.

5. Policy implications of improved wait-time measurement, monitoring and management

“The length of waiting times for the most important diagnoses and treatments is a litmus test of our health care system. These waiting times must be reduced. This will require fundamental reform and improvement in the facilities and the procedures of the entire health care system.”⁵⁶

Governor General Adrienne Clarkson

The wait-time problem in Canada has taken many years to develop and will not be resolved overnight. Many promising developments across the country point to significant improvements in the management of wait times and the delivery of timely care. There is some cause for concern over the short term, with limited system capacity placing an overall constraint on progress toward reducing wait times. The legal environment is also in flux, with at least one case before the Supreme Court with potentially significant implications for the management of wait times in Canadian jurisdictions.

Canada’s publicly-funded system, with no parallel private option, implies a commitment to equity under which clinical need rather than socioeconomic status determines access to service⁵⁷. Indeed, waiting lists are commonly associated with the universal access to care characteristic of publicly funded systems. The challenge, in the face of increasing demand and constrained resources, is to retain a commitment to fairness⁵⁸ while ensuring the timely delivery of services. Most Canadians would agree that random access to service fails to meet this goal. Forming a queue on the basis of order of arrival may have more appeal, but ignores clinical urgency. Services could be allocated according to patient characteristics, such as employment status or age, but this also seems contrary to accepted notions of fairness. Most Canadians would doubtless prefer a fourth method of structuring queues: allocation of service on the basis of relative clinical need⁵⁹. Implementing this goal thus becomes the core challenge in wait-time management.

How might this challenge be met? The following 10-point plan would contribute to an orderly and effective response to wait times in Canada:

1. Set priorities through broad consultation

With input from health care providers and the public, prioritize conditions or services that will be addressed, beginning with those of most clinical importance that are known to have long waits and gradually expanding the scope to include all services.

2. Address patient / public expectations through transparent communications

Inform patients and the public about the role that waiting lists and wait times play in the management of health services. Ensure transparency and improve confidence in the health system by informing patients how long they have to wait and how their priority is being determined with respect to other patients on the list.

3. Address immediate gaps in health human resources and system capacity

Commit to aggressive recruitment and retention strategies to fill gaps where scarcity of health human resources is the driving factor behind excessive wait times. Adopt a policy of increased self-sufficiency in the production of health professionals in Canada. Develop a needs-based planning framework to ensure that longer-term investments in physical and human resource capacity are made where they are most needed.

4. Improve data collection through investments in information systems

Continue to develop prospective data collection systems at the provincial level using standardized data definitions. Combine wait-time data held by individual health professionals and/or institutions, into a more efficient and centralized booking system, so as to serve a group of health professionals and/or institutions. Work with Canada Health Infoway Inc. to expand the use of information technology as a resource to improve coordination across health care providers and institutions.

5. Develop wait time benchmarks through clinical and public consensus

Establish benchmarks that incorporate clinical criteria and public preferences. To accelerate development of priority-setting tools and benchmarks for timely access across a full range of treatments, the federal government could build on the success of the Western Canada Waiting List Project and create centres of excellence in wait-time management with nodes across the country.

6. Strengthen accountability by way of public reporting

Publicly report on waiting times in a meaningful fashion. At the national level, commit to enhanced public reporting of interprovincial comparisons of wait times through the Canadian Institute for Health Information and the Health Council of Canada. Expand the use of online wait-list registries to provide up-to-date information on waiting times across regions and institutions.

7. Maximize efficiencies by aligning incentives properly

Increase inter-provincial collaboration to share capacity and develop centres of excellence for highly specialized care, supported by pan-Canadian referral networks. Reform hospital funding by moving toward activity-based funding to ensure that service provision is not artificially constrained by budget caps and can expand or contract as needed. Ensure that physicians are aware of clinical practice guidelines.

8. Address upstream and downstream pressures by investing in the continuum of care

Address pressure points in other related areas of the health care system by taking a “whole system” approach. Support the development of disease-management strategies at the regional

health authority level to provide for coordinated service delivery across prevention, primary care, acute care, home care, rehabilitation and long-term care.

9. Expand inter-jurisdictional care options by enhancing portability provisions

Enhance options available to patients when timely care is not available locally. Revisit in-country and out-of country portability provisions under the *Canada Health Act*, interprovincial reciprocal billing agreements and provincial health insurance legislation to streamline the process whereby patients may seek care in another jurisdiction when timely care is not available in their province of residence. Create a federal-provincial cost-shared Canada Health Access Fund to better support patients and their families that receive care outside their jurisdiction.

10. Commit to adoption of best practices through enhanced research and evaluation

Commit to a rigorous program of ongoing research and evaluation through the Canadian Institutes of Health Research, the Canadian Health Services Research Foundation and other granting bodies. Learn from success stories and best practices. As data become increasingly robust for individual services, expand research to include the prioritization of patients across services.

Managing wait times in Canada poses a systemic challenge which will not be resolved in the short term. Policy regarding wait time measurement, monitoring and management is evolving, and as such, each of the above-mentioned directives will be examined in greater detail in the coming months.

Appendix A: Operational principles for the measurement and management of wait lists

Preamble

The CMA Access to Quality Health Care Project has produced, to date, goals and principles relating to access to quality health care as well as *Operational principles for the measurement and management of waiting lists*. The latter were developed through a project advisory group with input from public opinion research as well as stakeholder groups, including CMA core councils and committees, CMA divisions and affiliates.

Goals

- To maintain or enhance patients' quality of life and health status through effective development and management of waiting lists.
- To ensure that the development and management of waiting lists are based on the best available evidence of clinical appropriateness, clinical effectiveness, rational use of resources, clinical need and quality of life.

Principles

A. Stakeholder involvement

Physicians in clinical practice must have a leadership role:

- in identifying clinically relevant data elements through consensus;
- in developing standard definitions and measures for prioritizing waiting lists; and
- in developing benchmark waiting times.

Health care providers and other stakeholders should be involved in the development, maintenance, monitoring, management and evaluation of waiting-list systems.

B. Database development and management systems

Systems for developing and managing waiting lists must require and provide reliable, current, useful and valid data and information.

Database development and waiting list management requires involvement of multidisciplinary panels.

Systems for managing waiting lists should:

- provide accurate, reliable, timely, publicly accessible and real-time information in a cost-effective manner;

- collect and assess data on need, quality of life and health outcomes; be flexible and dynamic so that they can adapt over time with the development of new technologies and approaches to treatment; and
- require policies and procedures on confidentiality, so that patients' and providers' privacy are protected.

C. Investment

Systems for managing waiting lists require initial and sustained investment in dedicated human resources, sophisticated information systems and information technology infrastructure.

D. Accountability

The parties involved in managing waiting lists must accept their responsibilities and obligations to each other and to the public.

Privacy and confidentiality of patient and provider information must be respected.

The systems, processes and results for managing waiting lists should be widely communicated to obtain stakeholder involvement and support.

E. Evaluation

Systems for managing waiting lists must:

- be continually monitored and evaluated to identify opportunities for improvement; and
- regularly undergo independent data audits and evaluations of process and outcome.

F. Governance

An independent, stakeholder-based, non-governmental organization with an advisory committee should be responsible for overseeing and administering systems for managing waiting lists.

Approved by the CMA Board of Directors, 27 Nov. 1999.

Appendix B: Provincial wait-time initiatives

	Monitored procedures	Method of data collection	Measurement standards	Priority-setting	Governance structure	Online info?
British Columbia	Cancer treatment; cardiac surgery; carotid endarterectomy; cataract surgery; corneal transplants; dental surgery; ENT surgery; eye surgery; gall bladder surgery; general surgery; gynecologic surgery; hip and knee replacement; neurosurgery; organ transplants; orthopedic surgery; plastic surgery; urologic surgery; vascular surgery	The Ministry of Health Services maintains the Surgical Wait List Registry to track wait times for a wide variety of surgical procedures at British Columbia hospitals. Cancer services and heart surgery are monitored in separate registries.	Provincial median wait times and the wait times listed for individual hospitals and surgeons are calculated from the wait times for surgeries and procedures performed over the past three months.	Standards have been set for a few services such as pediatric surgery. Individual physicians determine the urgency of the surgery or treatment needed for each patient.	The Ministry of Health Services funds and governs the management of surgical wait-time information and registries in British Columbia.	Yes
Alberta	Hip and knee replacement; cataract removal; cardiac surgery; MRI; cat scan; CT scan; radiation; chemotherapy; ENT surgery; gallbladder removal; general surgery; gynecological surgery; neurosurgery; orthopedic surgery; plastic surgery; urologic surgery	Alberta Health and Wellness compiles data submitted by urban and rural hospitals and diagnostic clinics. These facilities collect information from the physicians and other health care providers who perform the procedures included on the registry.	Each facility uses the same reporting process so that registry information is consistent across the province. The wait time submitted by hospitals to the registry comes directly from physicians. Waiting-time targets have been established for certain services.	Individual physicians determine the urgency of the surgery or treatment needed for each patient. There are three priority levels into which patients might be fit: normal, urgent and emergent (no waiting).	Alberta Health and Wellness funds and governs the management of wait-time information and registries in the province.	Yes
Sask.	Cardiovascular surgery; dental surgery; general surgery; neurosurgery; obstetrics and gynecology; ophthalmology; ENT surgery; plastic surgery; urologic surgery; cancer surgery	Currently, only Saskatoon and Regina Qu'Appelle collect and report surgical wait list data. However, the Saskatchewan Surgical Care Network is overseeing a number of initiatives aimed at improving the wait-list information provided to patients, health providers, physicians, regional health	A new patient-assessment tool ensures that all specialists are assessing patients and setting priorities using the same process with standardized tools. Health regions, the physicians and the department will be using the same terminology when	A priority classification table has been developed that assigns a priority level (I to VI) redefining the previous terms "emergent," "urgent" and "elective." These priority levels refer to the time frame in which a patient is optimally provided with the health service.	The Saskatchewan Surgical Care Network is an expert advisory committee appointed by Saskatchewan Health to oversee improvements to Saskatchewan's surgical system.	Yes

	Monitored procedures	Method of data collection	Measurement standards	Priority-setting	Governance structure	Online info?
		authorities and Saskatchewan Health.	discussing surgical care system issues. Waiting time targets have been established.			
Manitoba	Diagnostic imaging procedures (MRI, CT scan, ultrasound, stress MIBI and bone density) and radiation oncology therapy.	People who need non-urgent diagnostic testing or surgery are entered on wait lists. Those who need emergency surgery or treatment receive it without delay. They are not entered on a wait list.	Standards for wait-time measurement vary; in some cases, the reported waiting time reflects the time between the date of scheduling of the procedure and the date the procedure is scheduled to take place. In other cases, it reflects how long patients who recently had the procedure waited, which is considered an indication of how long patients who are still awaiting a procedure can expect to wait.	Prioritization determined according to the severity of the condition, the specialist to whom the GP is comfortable referring patients, changes to the capacity of particular hospitals or regions able to carry out the procedure.	The Manitoba Wait Time Reduction Plan is directly funded and governed by Manitoba Health.	Yes
Manitoba Cataract Waiting List Program	Cataract Surgery	A centralized database tracks and ranks all patients waiting for cataract surgery.	Booking request forms are submitted to the hospital at the time the decision to proceed with surgery is made. A record of completed operations is sent from the operating room to the MCWLP staff; the data from the entire waiting list are produced monthly and examined in depth twice yearly.	The scoring system is heavily weighted by the degree of functional impairment related to the cataract. A 14-item visual functioning index measures the severity of functional impairment based on common patient systems and their severity. Difficulty at work due to visual impairment and potential loss of driver's permit also factors into prioritization for cataract surgery.	The MCWLP was created as part of a contractual agreement between the Misericordia Health Centre and Manitoba Health in 1993.	
Ontario Cardiac Care	Cardiac surgery; bypass procedures	All patients accepted for cardiac surgery or bypass procedures are registered in	Waiting periods do not include time spent investigating disease before	Using a uniform scoring system, patients can be grouped according to the	CCN is an advisory body to the Ontario Ministry of Health and Long-Term Care	Yes

	Monitored procedures	Method of data collection	Measurement standards	Priority-setting	Governance structure	Online info?
Network		the Cardiac Care Network's computer system.	a patient is accepted for treatment by an interventional cardiologist. Waiting periods are counted from the date a patient was accepted for treatment by an interventional cardiologist. Each patient's interventional cardiologist decides when to schedule the procedure, working in conjunction with the referring physician, and makes arrangements with the patient. Waiting times may vary by cardiologist within hospital cardiac centres. Waiting-time targets have been established.	seriousness of their medical condition (urgent, semi-urgent or elective). Patients whose need for care is greatest should have the procedure first.	dedicated to improving quality, efficiency, access and equity in the delivery of cardiac services in Ontario. CCN is funded by the ministry.	
Quebec	<i>Monitored procedures:</i> cardiac surgery; diagnostic catheterization; angioplasty; radiation; cancer surgery; cataract surgery; hip and knee replacement; day surgery; other surgery requiring admission to hospital	Data are collected quarterly. For most institutions, the data are broken down monthly by date of referral and length of the waiting period. Only a few institutions provide data that are not broken down; methods for standardization are currently being developed.	The waiting period begins when an application for the required treatment is signed by the doctor and filed at the admissions office of the institution. The waiting period usually ends with delivery of the service. Waiting time targets have been set for a number of procedures.	Guidelines will ensure that all patients are treated according to the same criteria. In 2003, Quebec began to calculate the number of patients whose wait for surgery had "exceeded prescribed timelines" and was deemed medically unacceptable according to expert opinion.	Wait-list management is governed, managed, maintained and funded by the Ministère de la Santé et des Services sociaux.	Yes

CT = computed tomography; ENT = ear, nose and throat; Stress MIBI = Thallium and sestamibi stress test; MRI = magnetic resonance imaging.

	Monitored procedures	Method of data collection	Measurement standards	Priority-setting	Governance structure	Online info?
Nova Scotia	<i>Monitored Procedures</i> – (Current) Orthopedic Surgery; (Forthcoming) CT and MRI Scans.	Microsoft Access-based database will be expanded to include all orthopedic surgery locations in the province. <i>Proposed</i> that a scheduling system currently being implemented as part of the NS Hospital information system be tested to assess feasibility as a long-term solution to capture surgical data. In the long run it is proposed that operating room management software should be implemented province wide.	<i>Proposed:</i> with the exception of surgical services, wait times begin with the receipt of the referral by the specialist or dept, and end when the procedure is performed. Wait times for surgery start when the patient and surgeon agree that surgery is warranted, and end when the procedure is performed.	Surgeons are assigning a simple visual analogue scale score at the time of booking in order to assign a priority to the patient. The VAS is simple, quick, and appears to be a valid prioritization tool. Further validation work is required.	Wait times for health care services was highlighted as a priority by the Nova Scotia government in 2003. In November 2003, Nova Scotia announced \$15 million for new medical equipment that would speed up access to medical tests, treatment and care. This money came as a result of the first ministers' accord. In January 2004, the government committed to immediately enhancing services at the Queen Elizabeth II Health Sciences Centre and agreed to enhance access to long-term care beds.	No

Glossary

Accessibility, with respect to health care services, refers to the ease with which needed health care services can be obtained. This, in turn, depends on a range of factors including the availability of health care providers and facilities, travel distance to point of service and the financial cost to patients for the use of services.

Care guarantees provide patients with an assurance that they will have access to the treatment they need within a defined period of time. If patients are approaching or have exceeded the maximum allowable waiting time they may be entitled to seek care in another region or country with full public insurance coverage. Care guarantees have been implemented in various forms in a number of countries. In some cases, the guarantee has been *unconditional*, meaning that all patients are entitled to care within the prescribed time frame. Care guarantees may also be *conditional*, applying only patients with higher need, or a certain percentage of patients, who are subject to the maximum allowable waiting time.

Centralized management of wait times refers to systems put in place at the national, provincial or regional level to coordinate access across hospitals and health care providers and to ensure that patients in greater need receive care on a priority basis.

Maximum acceptable waiting time can be an arbitrary threshold or a clinically derived benchmark that varies across types of treatments and the severity of the condition.

Mean wait time means the arithmetic mean waiting period for treatment.

Median wait time means the waiting period at which half the patients have had a shorter waiting time and half have had a longer one.

Need can be reasonably equated with urgency. The ability to benefit is a clear and non-controversial component of deemed health care need¹².

Registries track patients who are waiting for a given procedure across hospitals in a region or province. Information recorded in registries includes the patient's demographics, severity of illness and length of time in the queue.

Relative priority may be defined as urgency with or without consideration of social factors¹².

Priority scoring systems provide decision-support tools to be used by health care providers to assess relative urgency and place patients on a centralized database or registry.

Timely access to health care refers to the delivery of care within a medically appropriate time frame.

Urgency refers to the extent to which immediate clinical action is required. Urgency also takes into account the expected benefit and the natural history of the condition¹².

Waiting lists are a feature of most publicly funded health care systems. A waiting list is a roster containing the names of people who are waiting for diagnostic or treatment services. Waiting lists can be maintained by individual physicians, institutions or government authorities.

Waiting time refers to the total period an individual must wait to receive care once a health problem has been diagnosed. It can also refer to the waiting period to access the first point of service in the health system, such as a family physician, community health centre or a hospital emergency ward.

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