CANADIAN ASSOCIATION OF RADIOLOGISTS

L'ASSOCIATION CANADIENNE DES RADIOLOGISTES

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Canadian Cardiovascular Society
Société canadienne de cardiologie

Canadian Ophthalmological Society
Société canadienne d'ophtalmologie

December 20, 2005

The Honourable George Smitherman
Chair, Conference of Health Ministers
Minister of Health and Long Term Care
Minister's Office
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON   M7A 2C4

Dear Minister Smitherman:

I am writing today on behalf of the Wait Time Alliance (WTA) to commend you and your colleagues on the Conference of Provincial and Territorial Health Ministers for coming together to produce pan-Canadian benchmarks aimed at reducing wait times for health care services.

While your recent announcement makes significant progress, it does not fully meet the commitments made by Canada's First Ministers with regard to benchmarks. Indeed, we hope that other provincial/territorial Health Ministers will follow your government with enhanced targets such as those you released December 16, 2005.

Questions also remain as to how to move forward on addressing some of the key barriers affecting timely access to quality health care services. Therefore, I would like to discuss the next critical steps that must be addressed in order to build on the momentum generated by your landmark announcement.

First, the decision of Health Ministers not to set wait time benchmarks in diagnostic imaging is of great concern since the ability to image the human body and its diseases has become central to the practice of modern medicine. Without proper access to diagnostic tools, the proposed benchmarks in cancer treatment, joint replacement and cardiac care may well be irrelevant. Accurate and timely treatment begins with accurate and timely diagnosis and in many cases that requires timely access to imaging services.

Clinicians feel strongly that the lack of existing evidence supporting specific benchmarks for computerized tomography (CT) and magnetic resonance imaging (MRI) is outweighed by the overwhelming evidence that these technologies are effective and essential in the management of cancer, cardiovascular and musculoskeletal diseases. The lack of benchmarks surrounding imaging technologies would seem to indicate a lack of understanding of the critical role, benefits and evidence surrounding the use and ability of imaging technologies to deliver timely quality care for Canadians. Similarly, members of the WTA also stand ready to work with governments to develop appropriateness criteria not only for MRI and CT but also PET (positron emission tomography), and other diagnostic imaging. This critical work may entail the creation of benchmarks for diagnostic services that involve different processes than those required for therapeutic procedures.

Second, the WTA is pleased that all provinces have agreed to establish a benchmark for cataract surgery and that some provinces, such as yours, have announced funding for additional surgeries to try and achieve this new benchmark. However, the December 12 press release announcing the benchmarks states the cataract surgery benchmark only applies to those with "high risk" cataracts that are "significantly impairing the ability to function without assistance." This wording is too vague and needs to be changed to the following: "Patients who have significant functional impairment, such that would impede their ability to perform their usual work and/or care for dependants and/or drive and/or read (the majority of patients on current waiting lists). This clarification reinforces the fact that the goal of the benchmarks is to set targets for the average rather than the exceptional patient. It is also important to reinforce a concept that we have maintained since the inception of the Alliance, that sight restoration does not represent cataract surgery alone. There are many other aspects to sight restoration that should be addressed such as retinal diseases, glaucoma and pediatric eye diseases. We hope that these areas will be considered in your further review of benchmarks.

Third, while the setting of a benchmark for bypass surgery is a good start, it should not be considered the end point. The patient's experience begins with the first sign of a symptom that might require care and does not end until the patient has completed a full cycle of diagnosis, treatment and rehabilitation. If a specialist cannot see a patient or arrange a stress test, a MIBI scan, or echocardiogram in a timely fashion, the patient's wait may be far too long even if the surgery waitlist is short. If a patient cannot get into a rehabilitation program after surgery, then the full potential of the procedure may not be realized. The Canadian Cardiovascular Society established benchmarks for the complete continuum of cardiovascular care: access to a general cardiology specialists and electrophysiology specialists, to stress testing, echocardiography, cardiac catheterization, angioplasty and all types of cardiac surgery, lifesaving implantable defibrillators, cardiac rehabilitation and heart failure management clinics to help patients help themselves and stay out of the hospital.

Further, bypass surgery is only used to treat one clinical condition, notably a blocked artery or arteries, and it is no longer even the most common intervention used to treat blocked arteries – twice as many patients have angioplasty now instead of surgery. Cardiac patients wait excessively long for other interventions, including six months for valve surgery and even longer for some potentially life-saving arrhythmia management consultations and life-saving

procedures. Even if the focus on bypass surgery were appropriate, the recommended maximum wait times (e.g. six months for elective surgery) are not necessarily the most appropriate benchmarks to use. This does not reflect new evidence in a field of care that has advanced significantly over the past decade. The more recent recommendations of the 50 Canadian physicians and healthcare professionals who developed benchmarks for cardiovascular services and procedures were based on contemporary clinical evidence and expert consensus.

Finally, the benchmarks announced for radiation therapy—four weeks from being 'ready for treatment' until the start of treatment—differ significantly from the WTA recommendation of two weeks. Indeed, Canadian Institutes of Health Research–sponsored scientific evidence suggests that the wait times for beginning radiotherapy for treatment for all types of cancer should be as short as possible. The WTA benchmark is consistent with international benchmarks.

The WTA also recommended a maximum wait of two weeks for the initial consultation with an oncologist. Clearly getting a foot in the door is the first step in subsequent timely treatment. There is no mention of a consultation benchmark in the pan-Canadian benchmarks released by Health Ministers, and this is an important omission. Although the Canadian Association of Radiation Oncology is pleased that progress is being made we consider the proposed benchmarks to be lax, and will adversely impact on cancer cure rates.

As you know, the WTA produced benchmarks based on best medical evidence for a comprehensive range of health services and procedures in each of the five priority areas earlier this year. WTA members also identified the key barriers to timely access, namely shortages of both health care professionals and capacity within the health care system. The WTA report included wait-time benchmarks for access to a specialist consultation in most of the key areas. In addition, our report warned that some 3.6 million Canadians had no regular family physician. This is a critical barrier to timely care since access to a family physician is usually required before a specialist consultation can occur. The issue of health human resources is a key piece that must be addressed in future work on wait times. Similarly, consideration must be given to the creation of a safety valve or publicly-funded Canada Health Access Fund to act as a safety valve to assure patients get access in cases where wait time benchmarks are exceeded.

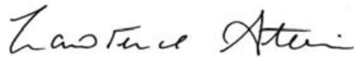
We believe your announcement lays a significant foundation for future work and we stand ready to collaborate on addressing the issues raised above. Although a good start, benchmarks alone will not provide Canadians with a guarantee of timely access. On behalf of our patients, members of the WTA—the physicians of Canada—look forward to working with you and your colleagues in an ongoing effort to achieve meaningful and sustainable reductions in wait times for quality health care services.

Yours truly,

Ruth Collins-Nakai, MD
Wait Time Alliance Spokesperson
President
Canadian Medical Association

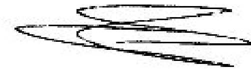
Peter Hollett, MD
President
Canadian Association of Nuclear Medicine

Tom Pickles, MD
President
Canadian Association of Radiation Oncology



Lawrence Stein, MD
Past-President
Canadian Association of Radiologists

Denis Roy, MD
President
Canadian Cardiovascular Society



Sherif El-Defrawy, MD
President
Canadian Ophthalmological Society

Robert B. Bourne, MD
President
Canadian Orthopaedic Association

cc: Provincial/Territorial Ministers of Health
Hon. Ujjal Dosanjh, Minister of Health
Hon. Carolyn Bennett, Minister of State (Public Health)
Dr. Brian Postl, Federal Advisor on Wait Times
CMA Provincial/Territorial Divisions