

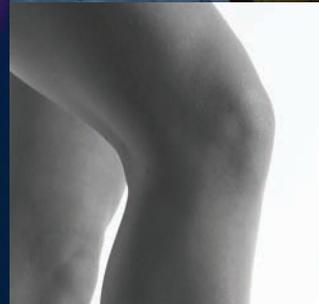
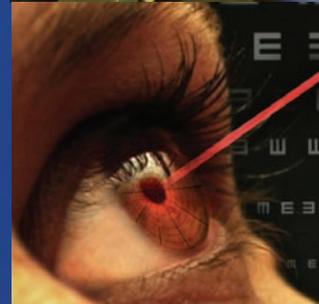
# Time's UP!

Achieving meaningful reductions in wait times

## PROGRESS REPORT

by the Wait Time Alliance for Timely Access to Health Care

APRIL 2007



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These benchmarks or performance goals have been developed by medical experts using the best evidence available at the time. They are not intended to be standards nor should they be interpreted as a line beyond which a health care provider or funder has acted without due diligence. Importantly, they do not take into account current constraints on the system's capacity to achieve these benchmarks.

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In addition the WTA thanks the following individuals and members of the Steering Committee.

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Canadian Cardiovascular Society  
Canadian Medical Association  
Canadian Ophthalmological Society  
Canadian Orthopaedic Association

# Executive summary

The Wait Time Alliance (WTA) was formed out of concern by Canada's doctors over delayed access to care for their patients and an interest in working collaboratively with stakeholders to improve wait times. In November 2006, the WTA released an interim report card that provided an initial assessment on how governments were performing in reducing wait times and meeting the wait-time provisions set out in the First Ministers' *10-Year Plan to Strengthen Health Care*. The report card was referred to as "interim" in recognition of the fact that the deadline set by First Ministers for showing meaningful reductions in wait times was 31 March 2007. Now that this important milestone has passed, the WTA is releasing this report along with a revised report card.

Specifically, this report addresses 2 main questions:

- How are we doing thus far in reducing wait times and improving access?
- Has a firm foundation been established to ensure that progress achieved to date can be sustained over the longer term?

The WTA was pleased to see that the recent federal budget allocated more than \$1 billion toward strategies that will help reduce wait times. This additional funding in Budget 2007 and the willingness of the provinces and territories to participate in these strategies signal renewed commitment to the issue of improving patient access by both levels of government.

Still, the WTA's assessment of the work undertaken by governments on their commitments in the 10-year plan indicates that further work is required including:

- completing the establishment of benchmarks in the 5 priority areas (i.e., for diagnostic imaging and the broader spectrum of cardiovascular care to reflect how care is delivered)
- announcing targets for implementing the benchmarks by 31 Dec. 2007;
- improving collection and reporting of wait times, including the adoption of a uniform set of starting points for measuring and reporting wait times (recommended starting points are provided in the report by the WTA).

This report and its accompanying report card assess whether meaningful reductions in wait times have been achieved and, if they have, whether they have been

achieved in a sustainable manner. It includes updates for each of the 5 priority areas.

Based on provincial data and assessments by medical specialists, it is clear that some progress has been made in reducing wait times in recent years. In some instances where wait times are not decreasing, resources are being increased, which should either lead to future reductions in wait times or allow the system to handle a surge in demand thereby preventing further increases in wait times. However, the WTA members point out that attention must be paid to factors such as demand for services and the supply of health care professionals, hospitals and equipment and how these resources are managed. This is critical to ensuring that any progress in reducing wait times can be maintained.

As we go forward, there remain some areas of unfinished business that require attention. First, initial steps are now being taken to implement a patient wait-time guarantee as a result of the creation of the federal government's new Wait Time Guarantee Trust. It will be critical to pursue a measured, coherent approach on patient wait-time guarantees, an approach that balances provincial flexibility with consistency in access from a patient's perspective by

- beginning with select procedures to implement the wait-time guarantee and evaluating before proceeding to other areas
- ensuring a proper fit between the benchmark and the point at which the guarantee takes effect
- having a plan in place to assist patients (and family caregivers) find the nearest appropriate treatment at no expense to the patient
- clarifying the responsibilities of patients, physicians and governments in using wait-time guarantees and identifying any possible legal considerations.

A second issue requiring attention is the "balloon effect" — the crowding out or reduction of resources for other health care services as a result of focusing too narrowly on the 5 priority areas. There is concern in the medical community over the emergence of "have" and "have not" disciplines. The WTA recognizes that Canadians expect timely access to all necessary care and steps must be taken to prevent any possible balloon effect. As part of an effort to ensure timely care beyond the 5 priority areas, the WTA is expanding its benchmark work beginning with the areas of emergency care, psychiatry, gastroenterology, anesthesiology and plastic surgery.

The WTA provides a set of recommendations focused on improving and sustaining the progress achieved to date to improve access to timely care. The recommendations are founded on a shared and continued commitment by all stakeholders — patients, health care providers and governments — to adopt the necessary practices to improve access to care for Canadians.

## Recommendations

1. To make wait-time reporting helpful and transparent to patients and the public alike, provincial governments, in conjunction with health care professionals, administrators and researchers, must undertake the following activities:
  - Clarify and standardize wait-time definitions and criteria among provinces, including the starting points proposed in this report.
  - Improve the quality and timeliness of reporting wait times on wait-time Web sites by:
    - reporting data several ways, including the percentage of population treated within the benchmark time
    - reporting (at a minimum) on a quarterly basis
    - having the data reviewed by the province's auditor general or an independent council.
    - Identify, measure and report on access enabler indicators affecting wait times to acquire a complete picture of whether reductions in wait times are being achieved on a sustained basis and whether any balloon effects are occurring.
2. In recognition of the fact that Canadians' health care needs extend beyond the 5 priority areas, all stakeholders must begin expanding their attention to develop benchmarks and wait times in other important areas of health care. The WTA will be an active stakeholder in this endeavour, as it was with the development of benchmarks for the initial 5 priority areas.
3. To make a truly meaningful and sustainable effort toward addressing health human resource (HHR) issues in Canada, health care professions and federal, provincial and territorial governments must adopt a pan-Canadian HHR strategy that begins with a needs-based, pan-Canadian, integrated HHR plan based on the principle of self-sufficiency for Canada. This strategy would be supported by a federal 5-year, \$1-billion Health Human Resource Reinvestment Fund.
4. To ensure the necessary capacity to support timely care for Canadians, the federal government must create a 1-time Health Delivery Infrastructure Fund that would help regional referral centres, teaching centres and hospitals to (re)build their capacity.
5. Canadians must recognize the role they play in affecting demand for health care services. The first step toward reducing wait times is to mitigate the need for the care in the first place, where possible, such as by adopting healthier lifestyles and properly managing chronic diseases and conditions with the support of health care professionals.

# Introduction

After several years of growing concern by Canadians over lengthy waits to obtain access to health care, Canadian governments agreed to take steps to rectify the problem. Indeed, the first priority outlined in the First Ministers' 2004 accord or *A 10-Year Plan to Strengthen Health Care* was to reduce wait times and improve access.<sup>1</sup> As a start, 5 priority areas were identified for achieving meaningful reductions in wait times: cancer, heart, diagnostic imaging, joint replacement and sight restoration.

No one said it would be easy to tackle growing waiting lists given the complexity of the issues involved. Nor, for that matter, did anyone suggest that a quick solution could be found. However, Canadians' desire to have more timely access to care is not a passing fad, as the issue remains a high priority for them.<sup>2</sup> That is why reducing wait times and improving access for Canadians requires a prolonged, concerted and coordinated approach.

The Wait Time Alliance (WTA) was formed out of the concern of Canada's doctors for their patients and an interest in working collaboratively with stakeholders to improve wait times (see box). In August 2005, the WTA released a set of wait-time benchmarks for the 5 priority areas.<sup>3</sup> In November 2006, it released an interim report card<sup>4</sup> that provided an initial assessment of how governments were performing in reducing wait times and meeting the wait-time provisions in the 10-year plan. The report card was referred to as "interim" in recognition of the fact that the deadline set by First Ministers for showing meaningful reductions in wait times was 31 Mar. 2007. Now that this important milestone has passed, the WTA is releasing this report along with a revised report card.

This report provides an independent, objective assessment of governments' progress to date on reducing wait times and is intended to ensure that governments honour their commitment to their 10-year plan. Specifically, this report addresses 2 main questions:

- How are we doing thus far in reducing wait times and improving access?

- Has a foundation been created to ensure that progress achieved to date can be sustained over the longer term?

This report is organized into 3 main sections. The first reviews governments' progress to date in honouring the commitments they made in the 10-year plan. The second reviews progress on actual reported wait times. The last section identifies some unfinished business that warrants attention, including recommendations and thoughts on next steps for governments and for the WTA.

## The Wait Time Alliance

The WTA comprises the Canadian Association of Radiology, the Canadian Association of Nuclear Medicine, the Canadian Association of Radiation Oncology, the Canadian Cardiovascular Society, the Canadian Ophthalmological Society and the Canadian Orthopaedic Association. Each of these organizations has involved clinical leaders in its respective specialties to support the WTA in an effort to reduce wait times. The Canadian Medical Association is also a member of the WTA, providing research and policy support.

Key releases by the WTA (available at [www.wait-timealliance.ca](http://www.wait-timealliance.ca)):

- WTA Interim Report Card,<sup>4</sup> November 2006
- *It's About Time*,<sup>3</sup> August 2005. Final report on achieving benchmarks and best practices in wait-time management
- *No More Time to Wait*,<sup>5</sup> March 2005. An interim report

# Progress toward meeting wait-time reduction commitments

The WTA was pleased to see that the recent federal budget allocated more than \$1 billion toward strategies that will help reduce wait times. This includes \$400 million for the Canada Health Infoway to develop provincial–territorial health records that will reduce wait times and up to \$612 million to support the implementation of provincial wait-time guarantees. These resources were added to the \$5.5 billion Wait Times Reduction Fund committed by the federal government in the 10-year plan. The additional funding in the 2007 budget and the interest shown by the provinces in participating in these strategies signal continued commitment to the issue of improving patient access by both levels of government.

Beyond funding, the First Ministers' 10-year plan made a number of commitments pertaining to reducing wait times for Canadians. In this section, we review each of those commitments and progress achieved to date.

## Access indicators

### Commitment

*Each jurisdiction agrees to establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be developed by all jurisdictions by 31 Dec. 2005.*

Indicators are critical to track progress, including progress toward meeting benchmarks. Although the *Final Report of the Federal Advisor on Wait Times*<sup>6</sup> issued last summer suggested that agreement had been reached on comparable indicators, governments have not yet released any details. In its recent annual report,<sup>7</sup> the Health Council of Canada noted that “these reports are still outstanding.”

In addition to the failure to establish public indicators, no provincial reports on comparable health indicators for 2006 have been released as promised under the 2000 First Ministers' accord.\*

## Development of wait-time benchmarks

### Commitment

*Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging proce-*

*dures, joint replacements, and sight restoration will be established by 31 Dec. 2005 through a process to be developed by federal, provincial and territorial ministers of health.*

The WTA's initial work centred on identifying wait-time benchmarks for the 5 priority areas announced in the 10-year plan. The WTA released its benchmarks in draft form in March 2005. Following extensive consultation with the public and other stakeholders, the WTA produced a final set of benchmarks in August 2005<sup>3</sup> with the recognition that wait-time benchmarks can change as new evidence comes forward.

In December 2005, the provincial ministers of health released their official wait-time benchmarks. Although there is some congruence between the 2 sets of benchmarks (Table 1), there are also some major differences. For instance, the health ministers did not provide any benchmarks for diagnostic imaging despite the fact that for approximately 40% of cases within the other 4 priority areas, diagnostic imaging is an important component in the overall treatment of a patient. Without proper access to diagnostic tools, the proposed benchmarks in cancer treatment, joint replacement and cardiac care may well be cold comfort for Canadian patients.

A second difference between the 2 sets of benchmarks pertains to cardiac care. Although the 10-year plan identifies “heart” as 1 of the 5 priority areas, provincial governments announced a benchmark only for bypass surgery. Although bypass surgery is important, it is no longer the most common intervention to treat blocked arteries; twice as many patients are now treated with angioplasty than surgery. The Canadian Cardiovascular Society has developed benchmarks, which are supported by strong evidence, for the complete continuum of cardiovascular care.

An important issue underlies the differences between the approaches used by the WTA and the provincial ministers of health. In its March 2005 report,<sup>5</sup> the WTA referred to the need for benchmarks to be based on evidence, but not “evidence-bound.” Clinical judgement based on interaction between clinicians and their patients is a critical component. “Making decisions based on only one source of information, such as limited research evidence, can lead to other problems as seen in managed care settings in the United States.”<sup>5</sup>

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\*The federal government did release a report of its own in 2006 on comparable health indicators covering the general Canadian population, First Nations and Inuit people and military populations.

**Table 1: Comparison of WTA and provincial wait-time benchmarks.**

Priority area	WTA benchmarks*	Provincial benchmarks†	Comments
Diagnostic imaging • Radiation - MRI - CT • Nuclear medicine - Bone scan - FDG-PET scan - Cardiac nuclear imaging	Within 30 days Within 30 days  Within 30 days Within 30 days Within 14 days	Not provided  Not provided	Timely treatment begins with accurate and timely diagnosis and in many cases this requires access to imaging services. The decision of provincial health ministers not to set wait-time benchmarks in diagnostic imaging is of great concern as the ability to image the human body and its diseases has become central to the practice of modern medicine.
Joint replacement Hip and knee replacement	Consultation within 3 months Surgery within 26 weeks of consultation	Surgery within 26 weeks	Wait times for consultation are a key issue in considering the overall wait time for joint replacements.
Ophthalmology • Cataract removal	16 weeks	Within 16 weeks for patients who are at high risk	The health ministers' benchmark for cataract surgery 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: "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)." The goal of the benchmarks is to set targets for the average rather than the exceptional patient.
Radiation oncology	Consultation within 2 weeks Treatment within 2 weeks from decision to treat	Within 4 weeks from decision to treat	The health ministers' benchmark of 4 weeks for radiation therapy — from "ready for treatment" until the start of treatment — differs significantly from the WTA recommendation of 2 weeks. According to evidence from CIHR-sponsored research, wait times for beginning radiotherapy for treatment for all types of cancer should be as short as possible.
Heart • CABG - urgent - elective	1–2 weeks 6 weeks	Non-emergency level I patients within 2 weeks Level II patients within 6 weeks Level III patients within 26 weeks	A 6-month benchmark for bypass surgery is not appropriate. Only 2%–3% of patients requiring bypass surgery are assigned a recommended maximum wait time in the Cardiac Care Network used in Ontario. The health ministers' setting of a benchmark for bypass surgery is a good start but far from complete and fails to recognize how medical care for heart patients is provided. The Canadian Cardiovascular Society has established benchmarks for the complete continuum of cardiovascular care based on strong evidence.

CABG = coronary artery bypass graft; CT = computed tomography; FDG-PET = fluorodeoxyglucose positron emission tomography; MRI = magnetic resonance imaging.

\* For scheduled cases.

† Released December 2005. [http://www.health.gov.on.ca/english/media/news\\_releases/archives/nr\\_05/nr\\_121205.html](http://www.health.gov.on.ca/english/media/news_releases/archives/nr_05/nr_121205.html)

## Establishing targets to meet benchmarks

### Commitment

*Multi-year targets to achieve priority benchmarks will be established by each jurisdiction by 31 Dec. 2007.*

Agreeing on benchmarks is an important step toward reducing wait times and improving system accountability to patients. Setting targets for meeting benchmarks is equally important; that is, by when can patients and the public expect the system to put into effect, and meet, the accepted wait-time benchmarks? Access targets need not be

achieved all in 1 step. For example, a jurisdiction could establish the following wait-time targets:

- By 31 Dec. 2006, 70% of patients are treated within the benchmark
- By 31 Dec. 2007, 80% of patients are treated within the benchmark
- By 31 Dec. 2008, 90% of patients are treated within the benchmark.

In the 10-year plan, the provinces agreed to set multi-year targets by 31 Dec. 2007. This is not a commitment to

meet targets, but rather a commitment to announce targets by that time. The federal government had announced that it wished to have targets in place by 31 Dec. 2006, but this plan did not come to fruition.

Based on a review of provincial Web sites, only Alberta and Ontario have targets in place. For the other jurisdictions, it is not clear how the benchmarks are to be used other than as a comparator for actual wait times. However, the recent announcement by the federal government and provinces that they will implement a patient wait-time guarantee for selected procedures will hasten the announcement of targets for these areas.

## Public reporting on progress

### Commitment

*Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait-time targets.*

Unfortunately, many provinces do not report wait times in relation to the provincially set benchmarks. This is surprising given that health ministers agreed to these benchmarks in December 2005.

Perhaps of greatest concern is the considerable variation in how wait times are reported. Atlantic provinces tend to report the percentage of the population receiving treatment within a given time period, whereas western provinces report median wait times (which only reveal the time in which at least half the population is receiving the treatment). Both Ontario and Alberta report wait times in both of these dimensions,\* as well as by average wait time. They, and to a limited extent Newfoundland and Labrador, have been the only provinces to report trends in wait times by procedure. In addition, some provinces still include emergency cases in their calculations, which can artificially reduce reported wait times.

In recent months, reports from the Health Council of Canada, CIHI and the WTA have all clearly stated that the lack of comparability of wait-time data among the provinces continues to be a serious problem, making it difficult to assess and compare progress. It is akin to flying a plane without instrumentation. We see few attempts to rectify this situation and we remain very troubled by this. Canadians expect and deserve better.

A key issue is the starting point that should be used for measuring wait time. Currently, governments use different

starting points. For example, for radiation oncology, various provincial governments measure wait time as

- from referral to cancer centre to treatment
- from consult to start of treatment
- from booking of treatment to date of treatment
- from decision-to-treat to treatment
- from ready-to-treat to treatment

In his 2006 report, the Auditor General of Ontario<sup>8</sup> noted that there can be an uncounted yet significant time lag from the date a booking is submitted by a surgeon to the date the surgery is entered into the system:

*In our sample of CT and MRI referral forms, if all the wait times had been measured from the time the completed referral form was received rather than from the time it was entered into the system, the reported wait time would have been an average of 13 days longer.*

There is also the critical period between the time when a patient receives a differential diagnosis from a family physician to the day the patient receives a diagnostic test or specialist consultation. Only a few provinces include the time a patient waits for a specialist consultation in their reporting. The different start times used by the provinces lead to confusion for patients, make comparisons very difficult and contribute to uncertainty regarding just how long patients are waiting.

To make the monitoring of wait times comparable and as patient-friendly as possible, the WTA believes that the following start times (Table 2) should be collected and reported for each of the 5 specialties.

In addition, the data should be reported publicly in the following ways: percentage of the population treated within the benchmark period; 90th percentile; median and average wait times; historical trends.

In response to a review by Senator Michael Kirby of Ontario's Wait Time Information System, the Government of Ontario recently announced the creation of an independent Wait Time Data Certification Council. The council will "review the processes on how the wait-time information is collected and reported prior to its public display."<sup>9</sup> The WTA commends the Government of Ontario for taking these steps to improve its reporting to the public and encourages the other provinces to follow suit.

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\*Ontario reports waits according to the point at which 90% of patients have received treatment.

**Table 2: Recommended periods for measuring and monitoring wati times by specialty.**

<b>Specialty</b>	<b>Recommended start times</b>
Radiation therapy	<ul style="list-style-type: none"> <li>• Referral to oncologist to date of consult</li> <li>• Ready to treat to date of first treatment (Data should be reported for several representative tumour sites)</li> </ul>
Joint replacement	<ul style="list-style-type: none"> <li>• Referral to orthopedic surgeon to date of consult</li> <li>• Date of booking received to date of treatment</li> </ul>
Cardiac care (including care for bypass surgery) (Note: A single patient will not necessarily require all these steps depending on their situation.)	<ul style="list-style-type: none"> <li>• Referral to cardiologist to date of consult</li> <li>• Referral for non-invasive test to date of test</li> <li>• Referral for invasive test (e.g., angiogram) to date of test</li> <li>• Referral to first visit at heart failure clinic</li> <li>• Ready to treat date to date of intervention (e.g., angioplasty, cardiac surgery, implantable cardioverter-defibrillator or pacemaker, ablation)</li> <li>• Date of intervention to start of rehabilitation</li> </ul>
Sight restoration	<ul style="list-style-type: none"> <li>• Referral to ophthalmologist to date of consult</li> <li>• Date of booking received to date of treatment</li> </ul>
Diagnostic imaging	<ul style="list-style-type: none"> <li>• Receipt of referral to day of test</li> </ul>

# Assessing meaningful reductions in wait times

## Commitment

*First Ministers commit to achieve meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration by 31 Mar. 2007, recognizing the different starting points, priorities, and strategies across jurisdictions.*

The passing of the 31 Mar. 2007 milestone set out in the 10-year plan provides an opportunity for a “check up” on whether access to timely care in the 5 priority areas has improved, particularly in a meaningful or sustained manner. After all, what matters most for patients is timely access to quality care.

Although the monitoring of wait times is important, so is the monitoring of the factors that can lead to reductions (or increases) in wait times. As shown in Figure 1, several “access enablers” can affect access and wait times beginning with initial demand, but including health system inputs and outputs. Each is discussed briefly below.

## Demand

Demand has a major role to play in wait times. Increased demand on a health care system that is unable to expand or increase output will lead to longer wait times. Demand can increase several ways: a change in demographics (e.g., growth in the size of the elderly population, increased levels of obesity); the availability of new technologies (e.g., new drugs or new diagnostic equipment and the subsequent “announcement effect,” whereby people become aware of the availability of these new treatments); and changes in treatment approaches for medical indications (i.e., a condition that makes a particular treatment or pro-

cedure advisable). An increase in surgical volumes may overlook the fact that the system is handling a surge in demand for surgery. If the system cannot meet this surge, wait times will increase.

## Inputs

System inputs include the supply of labour (e.g., physicians and nurses) and capital (see examples in text box below). They also include the processes that are involved in managing these resources, such as appropriateness, clinical care guidelines and payment structures (e.g., pay for performance). In the short term, inputs can be increased to reduce wait times or accommodate increased demand; for example, having staff work overtime and using equipment and facilities for longer hours. Increasing the supply of health care professionals is a longer-term strategy given the time it takes to train them.

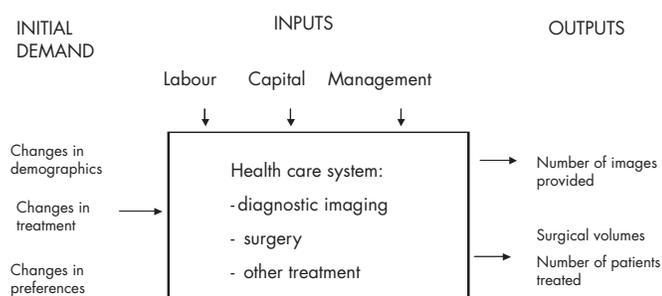
Not only are physicians a key input but they also play a significant role in managing inputs. Here are a few current examples.

- Implementing appropriateness guidelines: The Canadian Association of Radiologists (CAR) has produced comprehensive appropriateness guidelines for diagnostic imaging for physicians and is working with provincial governments to implement them.
- Assessing input capacity: CAR is also involved in compiling an inventory of diagnostic imaging equipment, a census of radiologists and technologists and a projection of future needs and supply.
- Learning best practices from others: The CMA, with its partners, has been involved in organizing an annual conference on wait-time management (Taming of the Queue conference series) that involves learning from best practices both nationally and internationally.
- Training professionals: The CMA is also developing a program to improve the skills required by health care professionals to manage wait times through a provider-designed and delivered program of training in wait-time management for physicians and other health professionals.

## Outputs

Outputs are the amounts of service, such as number of surgeries, provided over a specific period. Typically, one would

**Figure 1: Wait times: the big picture.**



expect to find an increase in health care services provided as part of a campaign to reduce wait times. A recent study released by the Canadian Institute for Health Information (CIHI)<sup>10</sup> noted that the number of surgeries in the priority areas (cataract removal, hip and knee replacement, heart surgery) had in fact increased by 7% after adjusting for population growth and aging.

However, as the CIHI report notes, an increase in surgical volumes (sometimes referred to as “flows”) does not necessarily mean a corresponding drop in wait times or “stocks.” This is due to the variety of factors at play shown in Figure 1 (e.g., growing demand and possible constraints on labour and capital inputs). Thus increasing the number of patients receiving services does not immediately mean shorter waiting times.

*“More people may become eligible for a procedure due to an aging and growing Ontario population that needs more health services. As well, more effective diagnostics, new clinical indications for treatment, and technological innovations may also increase demand. Improvements to access must outpace these increases in demand in order to reduce current wait times.”*

— Ontario’s Wait Time Strategy Overview, 8 Dec. 2004<sup>11</sup>

Alternatively, wait times may be decreasing, although at a pace that cannot be sustained for very long due to pressures on capital and labour or surging demand.

### Examples of inputs affecting wait times

#### Capital

- Bed capacity, including acute care beds, long-term care beds, surge capacity
- Day surgery capacity and home care services
- Availability of modern diagnostic equipment
- Availability of information technologies

#### Labour

- Availability of physicians: specialists and family physicians
- Availability of nurses
- Availability of other health care professionals (e.g., technicians)

#### Processes (flow)

- Guidelines for screening out inappropriate cases
- Funding incentives for taking on increased patient loads
- Regional referral networks and centres of excellence
- Pooled wait lists
- Centralized booking systems

The WTA’s report card<sup>12</sup> provides a more comprehensive assessment of performance on wait times by assessing the factors discussed above that can affect wait times.\* Subsequently, an “access enabler” component was added that provides an assessment of the soundness of these enablers or factors in supporting meaningful reductions in wait times by considering the following questions:

- Has there been an increase in resources directed toward reducing wait times since 2004?
- Have there been any improvements in the flow of patients (for example, through the use of appropriateness guidelines, clinical guidelines, centralized booking systems, prioritization tools)?
- Are the increases in output in the priority areas since 2004 adequate to meet future demand and are they sustainable over the longer term?

The inclusion of the access enablers component reflects the need for a more robust report card that takes into consideration all of the factors that can affect access over time (discussed further below under “Results by priority area”).

### Have we achieved meaningful reductions?

Based on our analysis of provincial wait-time Web sites, consultations with medical leaders from the 5 priority areas and a review of other recent wait-time reports,<sup>13,14</sup> it is clear that some progress has been made in reducing wait times in recent years. A comparison of wait times from 2005 to 2006 shows that where data exist, wait times have decreased for most procedures in most provinces.<sup>14,15</sup>

In some instances where wait times are not decreasing, resources are being increased that should either lead to future wait-time reductions or handle surging demand thereby preventing further increases in wait times. This is particularly the case for MRIs. Furthermore, processes have been introduced by health care professionals (e.g., patient priority systems) and governments in all provinces to improve patient flow and reduce wait times.

Despite the progress, in many cases the shorter wait times are still too long, and out of reach of both the provincial and WTA wait-time benchmarks. Furthermore, there remain very significant variations in wait times among regions within provinces. These variations can occur in different ways. For instance, in some cases rural residents have better access to medical care than their urban cousins due to lower demand.

A second and equally important issue is whether the reductions in wait times are sustainable. Have the necessary funding, structures and processes been put in place to ensure that the reductions can be maintained? As noted

\*The Institute for Clinical and Evaluative Sciences is currently undertaking an assessment of rates (and possibly waits for) surgical procedures that were covered versus not covered under Ontario’s *Wait Time Strategy*.

above, can further reductions be achieved in light of future patient demand?

The answers to these questions are not yet known. We do know that the supply of health care professionals has remained relatively constant for many years despite increased demand. Although medical school enrolment has increased, it will take 5–10 years before these students complete their training. As indicated below in the specialty reports, there are concerns by some specialists that the current pace of surgical volumes cannot be maintained for long with the existing supply of human resources. Likewise, there are instances where more operating room time and newer equipment (e.g., nuclear medicine) are required to address regional imbalances in wait times across the country.

## Results by priority area

The following section reports progress on wait-time reductions by specialty. Specific information on performance by province is provided in the WTA's report card.<sup>12</sup>

### Diagnostic imaging

Although the provinces chose to consider only CT scans and MRIs in setting benchmarks, from the outset, the WTA recognized the need to consider a broader range of

diagnostic imaging — one that includes both radiology and nuclear medicine.

**CT–MRI:** Significant investment in diagnostic imaging equipment over the past few years has increased capacity across the country. However, this increase has been matched by an even larger increase in demand. Until recently, the delay for MRI was so lengthy (6–12 months or even longer) that it was no longer used as a part of the diagnostic process for many patients. With new equipment available, more patients are being referred for MRI, resulting in little change in wait times or, in some cases, increased wait times, despite the fact that more imaging is being done than ever before. Average waits for MRI are 3–6 months and emergency cases are being seen as quickly as necessary.

The issue of appropriateness remains a key factor in efforts to reduce wait times. CAR has estimated that approximately 10% of requests for scans do not meet the appropriateness guidelines that have been adopted.<sup>16</sup> To be truly meaningful, the application of benchmarks must be made in concert with the use of appropriateness guidelines.

**Nuclear medicine** (see box): The Canadian Association of Nuclear Medicine (CANM) remains troubled by the lack of attention toward areas like bone mineral density, cardiac single photon emission computed tomography and basic bone scans. There are substantial variations in wait times for these services, particularly in Atlantic Canada, and access problems exist for general nuclear medicine procedures such as bone scanning, cardiac nuclear medicine procedures and bone mineral density measurement. Since 2004 access to PET imaging has increased, but there is a large variability in funding and approved indications from province to province resulting in inequitable access for Canadians.

In many situations, the equipment needs to be upgraded. Wait times for nuclear medicine have improved in the few instances where equipment has been upgraded, thereby increasing efficiencies.

### Joint replacement

In the area of joint replacement, attention has focused on reducing wait times for scheduled hip and knee replacements. Of the 5 priority areas, waits for hip and knee replacements have been among the lengthiest, particularly for knee replacements. A significant issue is the rise in demand, particularly among younger populations. The rate of hip and knee replacements grew by over 86% from 1994–95 to 2004–05; the largest increase occurred among those 45–54 years of age.<sup>17</sup> Although wait times for joint replacement have generally decreased despite the increased demand, the waits remain lengthy, with many patients still

#### Nuclear medicine's role in diagnostic imaging

Nuclear medicine is a specialty involving the use of radionuclides for the diagnosis and treatment of disease. The CANM has chosen 3 specific procedures for the development of wait-time benchmarks:

- Myocardial perfusion imaging, with either SPECT or PET technology, used for the diagnosis of coronary artery disease and in the assessment of patients with an established diagnosis of coronary artery disease.
- Radionuclide bone scanning: Except for a few limitations (multiple myeloma and histiocytosis X), radionuclide bone scanning is the primary imaging examination used to detect bone metastases. It is more sensitive than plain radiography and offers the advantage of providing a survey of the entire skeleton.
- F - fluorodeoxyglucose positron emission tomography (FDG-PET): Used to image cancer; this technology exploits the fact that many tumours hypermetabolize glucose. FDG-PET is a new technology that has emerged over the past decade and is now accepted and funded clinically in most countries of the Organization for Economic Cooperation and Development for the assessment of a number of tumours.

waiting beyond the provincially agreed benchmark.

There also remains a concern that patients are waiting far too long to receive a consultation with their orthopedic surgeon, which in many cases adds a significant component to the wait time.

### **Sight restoration (cataract surgery)**

Almost all provinces report dramatic reductions in wait times for cataract surgery. Some provinces have accomplished this by increasing the number of operating rooms (Ontario and Manitoba) while others have improved access to the resources available. In Saskatchewan, operating rooms were opened on Sundays to bring down the wait lists. The wait time in almost all provinces is now below the benchmark, yet there continues to be significant variation because of differences in length of individual surgeons' wait lists. The Canadian Ophthalmological Society supports the efforts proposed by some provinces to post the length of the wait list of individual physicians, so that patients or referring doctors or optometrists have the option of selecting a surgeon with a wait time below the benchmark.

A major problem emerging from the intense focus on cataract surgery is that it has come at the expense of attention to other sight-threatening conditions. According to anecdotal reports from different parts of the country, individual surgeons have indicated that they are now restricting their practice to cataract surgery because they are so busy. This leads to significant waits for people seeking care for other serious conditions, some of which are not as reversible as cataracts (macular degeneration, glaucoma, diabetic retinopathy). Health human resources need to be increased to maintain the increased rate of cataract surgery without compromising care in these other important areas.

### **Radiation oncology**

Across the country, wait times for radiation oncology have been either decreased or maintained over the past year. For example, despite a significant increase in demand, Ontario has reduced the median wait time from referral to start of

treatment by 33% across the province. However, there are continued difficulties in Newfoundland where some patients are still being sent to Ontario for radiation treatment. In Quebec, the situation is somewhat fragile, with pressure increasing partly due to linear accelerator replacement, which takes existing machines out of service temporarily. Health human resources are an additional issue with staff working late into the evenings. This will not be sustainable in the longer term due to burn out. Alberta still has significant waits for treatment of some tumour sites (e.g., prostate and breast).

The benchmark of the Canadian Association of Radiation Oncology and WTA is 2 weeks from the decision to treat to the start of radiotherapy, and it is hoped that cancer care agencies across the country can work toward this benchmark once the provincial health ministers' 4-week standard has been achieved.

### **Cardiac care**

An examination of wait times suggests that of the 5 priority areas, bypass surgery has achieved the greatest success in meeting provincial benchmarks. However, this apparent success story conceals a troubling reality.

- Timely access to bypass surgery for many patients remains an issue. Although some regions are able to meet the WTA benchmark of 6 weeks, many others have yet to do so.
- The narrow focus on bypass surgery has hindered any move to consider wait times for the more frequently used cardiac services, many of which are necessary for determining the need for bypass surgery or any other form of cardiac care. If it takes 3 months to obtain a specialist consultation and another 4 months to receive diagnostic catheterization, it does not really matter that the wait for bypass surgery is less than 6 weeks. The Canadian Cardiovascular Society has developed wait-time benchmarks for the full continuum of cardiac care. What is required is a commitment to use them.

# Unfinished business

Any credible assessment of the wait-time issue would be incomplete if it did not identify areas requiring further work. The following areas have been identified as needing additional attention over the months ahead.

## Continue with the development of benchmarks and targets

The 31 Dec. 2005 announcement by provincial governments on wait-time benchmarks is a good first step. But the effort cannot end there. No benchmarks have yet to be set for diagnostic imaging and, as we have pointed out, a broader array of benchmarks is required both within the 5 priority areas (e.g., in cardiac care and nuclear medicine) as well as beyond to capture accurately how care is provided to patients. Benchmarks are also required for patients waiting for a specialist consultation — an equally important component of the overall care process.

We are not aware of any ongoing efforts by health ministers to complete their work on establishing benchmarks, and the recommendation by the federal advisor on wait times (Dr. Brian Postl)<sup>6</sup> to establish a “trigger” mechanism to declare new benchmarks has not been acted on. Furthermore, more work is required on the setting of targets for adoption of the provincially agreed benchmarks.

## Creation of a wait-time guarantee

Establishing wait-time benchmarks is 1 step in securing timely care for Canadians. But benchmarks or performance goals alone can have minimal influence, which naturally begs the questions: what happens if a patient’s access to care exceeds the benchmarks? what recourse does the patient have? and what legal liabilities face physicians, health care institutions and governments? Physicians are increasingly raising concerns over whether they may be liable if patients they put into the queue are not seen within the allotted timeframe or if their appointment backlogs

prevent them from seeing a referred patient quickly enough.<sup>18</sup>

As previously noted, the government announced the creation of a Wait Time Guarantee Trust in the 2007 federal budget.\* Up to \$612 million will be put into a 3-year trust fund to support provinces and territories that have publicly committed to implementing patient wait-time guarantees in at least 1 of the 5 priority areas before 31 Mar. 2007. An additional \$30 million over 3 years has been set aside for provinces to undertake innovative patient wait-time guarantee pilot projects.<sup>19</sup>

At the time of preparing this report, several provinces had entered into agreements with the federal government to provide a care guarantee for such areas as cataract surgery, radiation oncology and bypass surgery.

The establishment of the trust is a new step in the right direction for addressing recourse for patients who face lengthy waits. As such, it will be critical to pursue a measured, coherent approach that balances provincial flexibility with consistency in access from a patient’s perspective. This could include:

- beginning with select procedures to implement the wait-time guarantee and evaluating before proceeding to other areas
- ensuring a proper fit between the benchmark and the point at which the guarantee takes effect†
- having a plan in place to help patients (and family caregivers) find the nearest appropriate treatment at no expense to the patient
- clarifying the responsibilities of patients, physicians and governments in using wait-time guarantees and identifying any possible legal considerations.

## Balloon effect

*It is not appropriate for our health care systems to be so focused on limited areas that we neglect others. While it is important to dedicate resources to shorten wait times for procedures and inter-*

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\*The federal government has also announced the funding of wait-time guarantee pilot projects for some populations falling under its jurisdiction, 3 of which pertain to diabetes care among select First Nations communities, and the development of a pediatric information system that will involve a pan-Canadian clinical recourse plan for children whose surgical wait times fall beyond clinic access guidelines.

†There can be a distinction between these times. The benchmarks speak to acceptable average wait-time ranges for patients. The wait-time guarantee applies to individual cases, specifically the outliers or tail on the wait-time distribution curve. Also, in situations where there is great dispersion of evidence or judgement concerning maximum wait times, a point along the distribution curve, the 90th percentile for example, could be used to initiate the care guarantee.

*ventions that are currently experiencing worrisome waits, it is also important to ensure that other diseases and conditions do not become the next areas to see wait times increase.*

— Dr. Brian Postl<sup>6</sup>

The “balloon effect” refers to a concern that an unintended impact of focusing on the 5 priority areas could be the crowding out or reduction of resources allocated for other health care procedures and services. This crowding out can take place within a specialty (e.g., more cataract surgery leading to fewer surgeries for other eye ailments), as well as between the 5 priority areas and other types of interventions such as pediatric surgery or general surgery. As noted in the Health Council of Canada’s most recent annual report,<sup>20</sup> “governments must continue to assess whether reducing wait times in the five targeted areas is crowding out wait times for other services.”

As mentioned, the recent CIHI report on wait times<sup>10</sup> found that while volumes for the 4 surgical priorities had increased by 7%, over the previous year, they had not decreased for other types of surgery (2% growth), possibly suggesting that no balloon effect is occurring.

However, surgical volumes alone are not sufficient to determine whether there is a balloon effect, as they do not reveal what has occurred in terms of demand for both priority and non-priority services (as shown in Figure 1). Unmet demand leads to longer wait times. Thus, while surgical volumes for the non-priority areas may not have decreased, a balloon effect may still have occurred in the form of longer wait times for these services. Moreover, we do not know what effect the announcement of the 5 priority areas may have had in attracting attention and resources to these areas. Thus, it is not surprising that a recent consultation with almost 4000 Canadian physicians found many reporting that they were seeing the emergence of “have” and “have not” disciplines.<sup>21</sup>

The WTA recognizes that the identification of the 5 priority areas in the 10-year plan was a first step to improve timely access to care and increase system accountability for patients. The WTA will continue to monitor progress on the 5 priority areas. As has been shown, there is still much

work to do on these fronts (e.g., set benchmarks for diagnostic imaging and for the full range of cardiac care). At the same time, the WTA recognizes that Canadians expect timely access to all necessary care, and steps must be taken to prevent a balloon effect. To that end, the WTA supports any efforts to establish wait-time benchmarks for health care services beyond the 5 priority areas identified in the 10-year plan (see also Recommendations and next steps).

## **Addressing Canada’s health human resources issue**

In its August 2005 report,<sup>3</sup> the WTA stated that the number 1 impediment to providing timely access to care was the shortage of health human resources (HHR). This is a long-term issue that will not be resolved quickly, notwithstanding some initial efforts by governments to increase HHR. In 2005, the WTA called for the establishment of a \$1-billion Health Human Resource Reinvestment Fund to support the implementation of a needs-based, pan-Canadian, integrated HHR plan based on the principle of self-sufficiency for Canada. Essential elements of this plan include continued increases in undergraduate education opportunities for health professionals (physicians, nurses, technicians and others), increases in the availability of postgraduate training positions, accelerated integration of qualified international health workers and the creation of a Canadian coordinating office for HHR.

With respect to medicine, there has been some progress in this area as governments have increased medical school enrolments and postgraduate training positions, and facilitated the integration of qualified foreign-trained health care providers. But an adequate supply of other health care professionals is also necessary to address lengthy wait times effectively.

The bottom line is that a national approach to addressing Canada’s future supply of HHR must be followed or Canada will face another balloon effect — this time a HHR balloon effect — with some parts of the country benefiting while others face lengthier waits for necessary care.

# Recommendations and next steps

This section provides key recommendations based on the current status of access to care and efforts to achieve meaningful reductions in wait times. It also identifies the next steps that will be taken by the WTA in the months ahead.

## Recommendations

The recommendations below bring us back to the beginning of this report and our call for a prolonged, concerted and coordinated approach to improve patients' access to timely care. These recommendations reinforce the fact that reducing wait times cannot be accomplished by a single player, but rather requires coordinated efforts by governments, health professionals and the public.

1. To make wait-time reporting helpful and transparent to patients and the public alike, provincial governments, in conjunction with health care professionals, administrators and researchers, must undertake the following activities.
  - Clarify and standardize wait-time definitions and criteria among provinces, including the starting points proposed in this report.
  - Improve the quality and timeliness of reporting wait times on wait-time Web sites by
    - reporting data several ways, including the percentage of the population treated within the benchmark time
    - reporting (at a minimum) on a quarterly basis
    - having the data reviewed by the province's auditor general or an independent council.
  - Identify, measure and report on access enabler indicators affecting wait times to acquire a complete picture of whether reductions in wait times are being achieved on a sustained basis and whether any balloon effects are occurring.
2. In recognition of the fact that Canadians' health care needs extend beyond the 5 priority areas, all stakeholders must begin expanding their attention to develop benchmarks and wait times in other important areas of health care. The WTA will be an active stakeholder in this endeavour, as it was with the development of benchmarks for the initial 5 priority areas.
3. To make a truly meaningful and sustainable effort toward addressing HHR issues in Canada, health care professions and federal, provincial and territorial governments must adopt a pan-Canadian HHR strategy that begins with a needs-based, pan-Canadian, integrated HHR plan based on the principle of self-sufficiency for Canada. This strategy would be supported by a federal 5-year, \$1-billion Health Human Resource Reinvestment Fund.
4. To ensure the necessary capacity to support timely care for Canadians, the federal government must create a 1-time Health Delivery Infrastructure Fund that would help regional referral centres, teaching centres and hospitals to (re)build their capacity.
5. Canadians must recognize the role they play in affecting demand for health care services. The first step toward reducing wait times is to mitigate the need for the care in the first place, where possible, such as by adopting healthier lifestyles and properly managing chronic diseases and conditions with the support of health care professionals.

## Next steps

The WTA will be undertaking several important activities in the months ahead. They are briefly outlined below.

### Expansion of WTA

Given the WTA's interest in improving access and its support for establishing benchmarks for types of care beyond the 5 priority areas, the WTA will be expanding in the near future to incorporate other areas, such as emergency care, psychiatry, gastroenterology, anesthesiology and plastic surgery.

In a separate but related initiative, the College of Family Physicians of Canada (CFPC) and the CMA will be working together to consider wait-time benchmarks or performance goals in the area of primary care, specifically concerning access to family physicians. As noted in the WTA's August 2005 report,<sup>3</sup> the wait begins for most patients when they try to access their family physician. Worse still, many Canadians — 14% according to Statistics Canada<sup>22</sup> — report not having a regular family physician.

***Advocate that governments meet commitments in the 10-year plan***

The next milestone under the 10-year plan is the announcement of multi-year targets by 31 Dec. 2007. This would mean that those provincial governments that have not already done so would announce their timelines for implementing the agreed wait-time benchmarks. The WTA will be closely following this milestone as we

believe it is another key step on the road to improving access.

***Prepare for 2008 Parliamentary review***

The federal legislation passed to implement the funding commitments of the 10-year plan provides for a Parliamentary review of the plan in 2008 and 2011 to assess progress. The WTA will be participating in the 2008 review with a more comprehensive report and assessment at that time.

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