Wait Time Alliance
Report, *Fall 2007*

Time for Progress

New benchmarks for achieving
meaningful reductions in wait times

Published by the Canadian Medical Association, November 2007

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.

Additional copies are available from
Member Service Centre
Canadian Medical Association
1867 Alta Vista Drive
Ottawa ON K1G 3Y6
888 855-2555 or 613 731-8610 x2307
msc@cma.ca
cma.ca

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Acknowledgements

This report was prepared by the Canadian Medical Association (CMA) as a member of the Wait Time Alliance (WTA).

The WTA acknowledges the work of those individuals for the reports that are included in this document. As well we thank CMA staff who have been intimately involved with the production of this report.

Wait Time Alliance members*

Canadian Anesthesiologists' Society
Canadian Association of Emergency Physicians
Canadian Association of Gastroenterology
Canadian Association of Nuclear Medicine
Canadian Association of Radiation Oncologists
Canadian Association of Radiologists
Canadian Cardiovascular Society
Canadian Ophthalmological Society
Canadian Orthopaedic Association
Canadian Medical Association
Canadian Psychiatric Association
Canadian Society of Plastic Surgeons

*See Appendix C for a complete list of names and addresses.

Executive summary

It has been over 3 years since *A 10-Year Plan to Strengthen Health Care* was signed by first ministers. A key feature of the plan was a series of commitments to reduce lengthy wait times in Canada, ranging from developing wait-time benchmarks for 5 priority areas by December 2005 (diagnostic imaging, hip and knee replacement, radiation oncology, cataract surgery and cardiac care) to showing meaningful reductions in wait times by March 31, 2007.

In its April 2007 report, the Wait Time Alliance (WTA) stated that some progress had been made in reducing wait times in recent years and, where reductions had not yet occurred (e.g., diagnostic imaging), steps were being taken to increase output and improve patient flow. The WTA maintains the view that these encouraging signs do not mean that the wait times issue has been resolved. Furthermore, work on reducing wait times should not be limited to the 5 priority areas.

This report signals the WTA's commitment to reducing lengthy wait times beyond those areas. In April 2007, the WTA announced that it had expanded its focus to include 5 additional medical specialties: emergency care, psychiatric care, plastic surgery, gastroenterology and anesthesiology. This report features wait-time benchmarks for these specialties.

Five new sets of benchmarks

A wide range of wait-time benchmarks or performance goals have been developed by the Canadian Psychiatric Association, the Canadian Association of Emergency Physicians, the Canadian Society of Plastic Surgeons and the Canadian Association of Gastroenterology and are featured in this report. The objective of the Canadian Anesthesiologists' Society's participation in the WTA's work is twofold: to provide wait-time benchmarks in the area of pain management; and to be linked to the development of wait-time benchmarks by other WTA specialties given the anesthesiologist's role as a member of the surgical team.

The specific method used by each of the participating specialties, as for the initial set of WTA benchmarks, involved reviewing available clinical evaluations or epidemiologic evidence on wait-time thresholds, reviewing existing standards of access, where available, and holding consultations and other exchanges among specialty members to review and consider wait-time targets. The process also continued to follow an "evidence-based" rather than an "evidence-bound" approach: insufficient or inconclusive research evidence should not stop the process of identifying wait-time targets, as decisions must be made based on the best evidence available.

These wait-time benchmarks should not be construed as standards. They should be viewed as health system performance goals that reflect a broad consensus on medically reasonable wait times. Every patient is unique and has different care needs. Nevertheless, for the most part, these benchmarks should be viewed as "maximum acceptable" wait-times, not "ideal" wait times.

A common theme in the specialty-specific reports summarized below is the current and forecast shortage of specialists. Although meeting the wait-time benchmarks requires a number of steps, it must begin with addressing shortages in health human resources (HHR), not only among the specialties covered by these benchmarks, but also among other medical professional groups, including family physicians, nurses and health care technicians. That is why the WTA has consistently called for a pan-Canadian HHR strategy based on the principle of self-sufficiency for Canada. The *Framework for Collaborative Pan-Canadian Health Human Resources Planning* prepared by the federal/provincial/territorial Advisory Committee on Health Delivery and Human Resources represents a start toward achieving this goal.

Although HHR remains the biggest challenge to improving timely access to care, the specialties featured in this report have also made the case that infrastructure gaps need to be addressed. These gaps include hospital acute care beds, alternative level of care beds, operating theatres, diagnostic suites and community services.

In addition to the HHR shortages and insufficient infrastructure, the WTA's work over the past year highlights an alarming lack of standardized data suitable for monitoring progress in reducing wait times. Wait-time data are captured and reported differently across the country. In addition, as noted previously by the WTA, jurisdictions use different starting points when measuring wait times, which often leads to distortions in the actual time the patient waits. The lack of comparable data makes monitoring and cross-jurisdiction comparisons extremely difficult and leaves patients and governments largely in the dark as to what progress is being made.

Summary sample of wait-time benchmarks by priority level*.

Specialty and procedure	Wait-time benchmark		
	Emergency cases	Urgent cases	Scheduled cases
Emergency care	Level 1: Immediate (e.g., cardiac arrest) Level 2: < 15 min (e.g., chest pain) Level 3: < 30 min (e.g., moderate asthma) Level 4: < 60 min (e.g., minor trauma) Level 5: < 120 min (e.g., sprains)	Not applicable	Not applicable
Psychiatric care (e.g., psychosis, mania, major depression) • Access to family practitioner for acute mental health concerns • Access to psychiatrist after referral by family physician	 As deemed appropriate after triage Within 24 h	 Within 24 h Within 1–2 weeks	 Within 1 week Within 2–4 weeks
Plastic surgery	Within 24 h (e.g., infections, burns, hand and facial trauma)	Within 2–8 weeks (e.g., most malignant neoplastic conditions, some craniofacial conditions)	Within 2–6 months (e.g., congenital anomalies, wounds, most elective hand procedures)
Gastroenterology (includes time from referral to consultation and/or treatment/procedure when indicated)	Within 24 h (e.g., acute gastrointestinal bleeding, acute severe hepatitis)	Within 2 weeks (e.g., high likelihood of cancer, painless obstructive acute jaundice) Semi-urgent: Within 2 months (e.g., iron-deficiency anemia, chronic diarrhea)	Within 6 months (e.g., screening colonoscopy, chronic gastroesophageal reflux disease)
Anesthesiology — pain management (wait time for first assessment by pain subspecialist after referral by primary physician)	See Table 8.		

*Priority or urgency levels are defined as follows: emergency = immediate danger to life, limb or organ; urgent = situation is unstable and may deteriorate quickly resulting in an emergency admission; semi-urgent = situation involving some pain, dysfunction and disability but patient is stable and unlikely to deteriorate quickly to the point of needing emergency care; scheduled = situation involving minimal pain, dysfunction or disability (also called "routine" or "elective").

Clearly, it will be a challenge to measure and monitor new wait-time benchmarks when we have thus far been unable to do this accurately for a select few. Greater effort is required by all parties to capture wait-times data to determine with greater certainty whether any progress is being made, given the sizeable funding allocations provided by governments.

Next steps

Two key milestones are on the horizon regarding wait-time benchmarks and commitments pertaining to *A 10-Year Plan to Strengthen Health Care*. First, by Dec. 31, 2007, provinces and territories are to announce multiyear targets for meeting the wait-time benchmarks. Although some jurisdictions are operating on the basis that the benchmarks are now in effect, for most it is not clear how and when they will take effect. The WTA is calling for announcements from provinces and territories on this matter between now and the end of the year.

The second milestone is a review of the 10-year plan. The federal legislation passed to implement funding commitments for the plan provides for Parliamentary reviews in 2008 and 2011 to assess progress. The WTA will be an active participant in the spring 2008 review and will release another report card on progress toward improving access to timely care for Canadians.

Recommendations

Based on its work in the development of wait-time benchmarks, the WTA recommends:

1. With respect to meeting the commitments agreed to in the first ministers' 10-year plan,
   i. Governments accept all outstanding wait-time benchmarks outlined in the WTA's 2005 report, *It's About Time*, that have not yet been adopted (i.e., cardiac care and diagnostic imaging)
   ii. Governments announce multiyear targets for meeting wait-time benchmarks in the initial 5 priority areas by Dec. 31, 2007.
2. With respect to patient wait-time guarantees for the initial 5 priority areas,
   i. Provincial governments adopt patient wait-time guarantees for each of the initial 5 priority areas by Dec. 31, 2007, that involve a publicly funded method of recourse for patients facing waits that exceed benchmark thresholds
   ii. Provincial governments standardize the conditions of their patient wait-time guarantees to ensure comparable guarantees for all Canadians
   iii. Governments issue regular progress reports (e.g., semi-annual) on the status of implementing their patient wait-time guarantees.
3. With respect to the WTA's new wait-time benchmarks,
   i. Governments adopt the new wait-time benchmarks provided in this report on a pan-Canadian basis and begin to promote their use as part of an effort to move beyond the initial 5 priority areas
   ii. Where it has not yet occurred, governments expand their collection and reporting of wait-time data beyond the 5 priority areas
   iii. Federal government commit new funding to
      - assist provinces and territories to provide timely access to care for the services addressed under the new set of wait-time benchmarks including funding in the area of HHR
      - support the Canadian Institutes of Health Research in wait-time benchmark development research and the Canadian Institute for Health Information in the adoption of comparable wait-time data that accurately reflect the length of time patients wait for access to care.

Introduction and purpose of this report

Over 3 years ago, Canada's first ministers signed the 2004 accord, *A 10-Year Plan to Strengthen Health Care*.[1] A key feature of this plan was a series of commitments to reduce lengthy wait times, ranging from developing wait-time benchmarks for 5 priority areas by December 2005 (diagnostic imaging, hip and knee replacement, radiation oncology, cataract surgery and cardiac care), to achieving meaningful reductions in wait times by March 31, 2007.

The April 2007 Wait Time Alliance (WTA) report[2] noted that some progress has been made in reducing wait times in recent years and, where reductions have not yet occurred (e.g., diagnostic imaging), steps are being taken to increase output and improve patient flow. However, the WTA has warned that these encouraging signs do not mean that the wait-times issue has been resolved. Rather, reducing wait times must be seen as a starting point toward improving access to the full continuum of health care and strengthening health system accountability. Reducing lengthy wait times serves as a unifying objective for funders, providers and patients alike. Going forward, the wait-times agenda provides increased focus for the processes involved in managing wait times and how different parts of the system need to interconnect.

Despite progress, there has been criticism over the focus on wait times, more specifically, the focus on addressing wait times for only 5 conditions and often only a narrow range of procedures within them. Critics point out that health care goes beyond the 5 priority areas and that focusing on these 5 will mean resources will not be directed to other areas or may even be redirected away from them. Indeed, the need to look beyond the 5 priority areas was a prominent theme at the 2007 Taming of the Queue IV conference, a gathering of wait-time experts who have been meeting annually to exchange ideas and assess progress on reducing wait-times.[3]

To be fair, work on reducing wait times does not have to be limited to the initial 5 priority areas. Indeed, the Ontario Wait Time Strategy stated, "the five areas were just the beginning of an ongoing process to improve access to, and reduce wait times for, a broad range of health care services." [4]

From the outset, the members of the WTA considered the initial 5 clinical areas to be just that: a starting point. In April 2007, the WTA announced the next step by expanding its focus to include 5 additional medical specialties ready for the development of wait-time benchmarks: emergency care, psychiatric care, plastic surgery, gastroenterology and anesthesiology. Developing wait-time benchmarks for these specialties, as for the initial 5, has helped foster important discussions among specialists regarding what ought to be acceptable wait times for their patients and how they may be reduced.

This report presents wait-time benchmarks for what the WTA is calling "the next 5." These clinical areas represent specialties in which thousands of Canadians require treatment every day. Addressing them represents the next step in the WTA's ongoing effort to ensure timely access to a broad range of medical care for patients.

Work accomplished to date

In winter 2005, the WTA released an interim set of wait-time benchmarks for the initial 5 priority areas (diagnostic imaging, hip and knee replacement, radiation oncology, cataract surgery and cardiac care); these served as the basis for a comprehensive stakeholder consultation. Subsequently, the WTA released a report in August 2005[5] that included a comprehensive range of wait-time benchmarks (see Appendix A).

Provincial governments announced a partial set of wait-time benchmarks in December 2005 (as agreed to in the 2004 10-year plan). Although this was viewed as a good start, the WTA has previously noted the deficiencies in governments' benchmarks: they remain incomplete and need further work. For example, while the WTA has provided a complete range of wait-time benchmarks for cardiac care, the provincial governments have announced a benchmark only for bypass surgery.

The need to expand beyond the initial 5 priority areas

In addition to the WTA's work to develop wait-time benchmarks for the initial 5 priority areas and the 5 new specialties (covered in this report), other groups have been active in setting wait-time benchmarks. Benchmarks for pediatric surgery have been developed by the Ontario Children's Health Network (OCHN) and subsequently embraced by a number of pediatric organizations.[6] The College of Family Physicians of Canada (CFPC) and the Canadian Medical Association (CMA) are collaborating on strategies to improve access to timely primary medical care. This partnership focuses on the waits that some Canadians experience before finding a family physician, being seen by a family physician and obtaining diagnostic testing and specialist consultation.

Achieving meaningful reductions in wait times

The 10-year plan included a commitment to achieve meaningful reductions in wait times by March 31, 2007. Coinciding with this milestone, the WTA released a report card titled *Time's Up* in April 2007.[2] Notwithstanding the lack of comparative data on wait times, the WTA reported that progress has been made in improving timely access for some surgical procedures across the country. However, these findings should by no means be construed as "mission accomplished." Continuing effort is required and the WTA has issued several recommendations including the need to create a national health workforce strategy.

Patient wait-time guarantees

The WTA has been calling for a publicly funded patient wait-time guarantee that would be linked to the wait-time benchmarks. In its 2007 budget, the federal government announced up to $612 million for a trust to help accelerate the implementation of patient wait-time guarantees. In addition to a "signing bonus" of $10 million per province and $4 million per territory, up to $500 million would be allocated on an equal per capita basis to provinces and territories via a third-party trust. Provinces must identify at least 1 of the 5 priority areas in which to implement a patient wait-time guarantee. As well, an additional $400 million was committed for the Canada Health Infoway to support provincial and territorial development of electronic health records that, among other things, will contribute to reducing wait times.[7]

At the Taming of the Queue IV conference in April 2007, the Prime Minister announced that all provinces and territories had agreed to participate in the Patient Wait Times Guarantee Trust. Accessing the fund involves the following core elements:

- a defined time frame establishing when medically necessary health care services should be delivered
- access to alternative options of care that are automatically offered to patients if the system fails to deliver treatment within the defined time frame.

The procedures selected by the provinces and territories vary considerably (Appendix B). Six provinces have chosen radiation oncology as the area in which to apply a wait-time guarantee; 2 provinces chose bypass surgery and 1 province (Ontario) chose cataract surgery.

There has been considerable criticism of how this new funding is being applied. Except for Quebec, no province or territory has selected more than 1 procedure. In addition, although several provinces chose radiation oncology, the time frame for the guarantee differs among the provinces (8 weeks in Nova Scotia, Prince Edward Island, New Brunswick, Alberta and British Columbia versus 4 weeks in

Manitoba), and significantly exceeds the WTA recommended maximum wait time of 2 weeks, and with the exception of Manitoba, exceeds provincial governments' benchmark of 4 weeks. Eight weeks is also well beyond the waiting period patients currently face as reported on the provinces' wait-time Web sites. Finally, for many provinces, the guarantee will not come into effect until 2010.

Notwithstanding these shortcomings, the WTA believes that acceptance of the concept of a patient wait-time guarantee by the provinces is a step forward in improving timely access to care and improving system accountability for patients — as was their acceptance of the concept of wait-time benchmarks. At the same time, the WTA has recommended that provincial governments adopt patient wait-time guarantees for all 5 priority areas by the end of the year. Meanwhile, the WTA will monitor the use of the trust fund and track the progress that has been achieved by the provinces and territories.

Defining benchmarks for the WTA's new specialties

This section contains the wait-time benchmarks set by the newest members of the WTA — the Canadian Association of Emergency Physicians, the Canadian Psychiatric Association, the Canadian Society of Plastic Surgeons, the Canadian Association of Gastroenterology and the Canadian Anesthesiologists Society — including the methods used to develop them, what is known about wait times in these specialties in comparison to the benchmarks and a discussion of key factors affecting wait times for each specialty. The objective of the Canadian Anesthesiologists' Society's participation in the WTA's work is twofold: to provide wait-time benchmarks in the area of pain management; and to be linked to the development of wait-time benchmarks by other WTA specialties given the anesthesiologist's role as a member of the surgical team.

As in the original set of benchmarks, the process for determining the new wait-time benchmarks must respect the first principles created by the WTA in 2005 (Exhibit A).

The specific method used by each of the participating specialties, as for the initial set of WTA benchmarks, involved reviewing available clinical evaluations or epidemiologic evidence on wait-time thresholds, reviewing existing standards of access where available, and holding consultations and other exchanges among specialty members to review and consider wait-time targets. The process also continued to follow an "evidence-based" rather than an "evidence bound" approach: insufficient or inconclusive research evidence should not stop the process of identifying wait-time targets, as decisions must be made based on the best evidence available. A glossary of key wait-time terms is provided at the end of this report.

Figure 1 shows the framework used by the WTA in its development of wait-time benchmarks. Each of the new specialties brings a unique perspective, building on the initial benchmark development work of the WTA. As previously mentioned, the WTA also supports the efforts of the CFPC and the CMA in their work to identify strategies for improving Canadians' access to primary medical care and how they fit in with the other benchmark development work.

A summary of the wait-time benchmarks is provided in Table 1. This table does not include all the benchmarks developed by the new specialties, but rather a sample. A complete list of benchmarks can be found on the WTA Web site www.waittimealliance.ca/index.htm.

Exhibit A: WTA's first principles to guide development of wait-time benchmarks

The WTA believes that wait-time benchmarks should be developed for all essential health care services. It has identified 10 principles that will govern its work toward the development of wait-time benchmarks and ultimately more timely access to care for all Canadians.

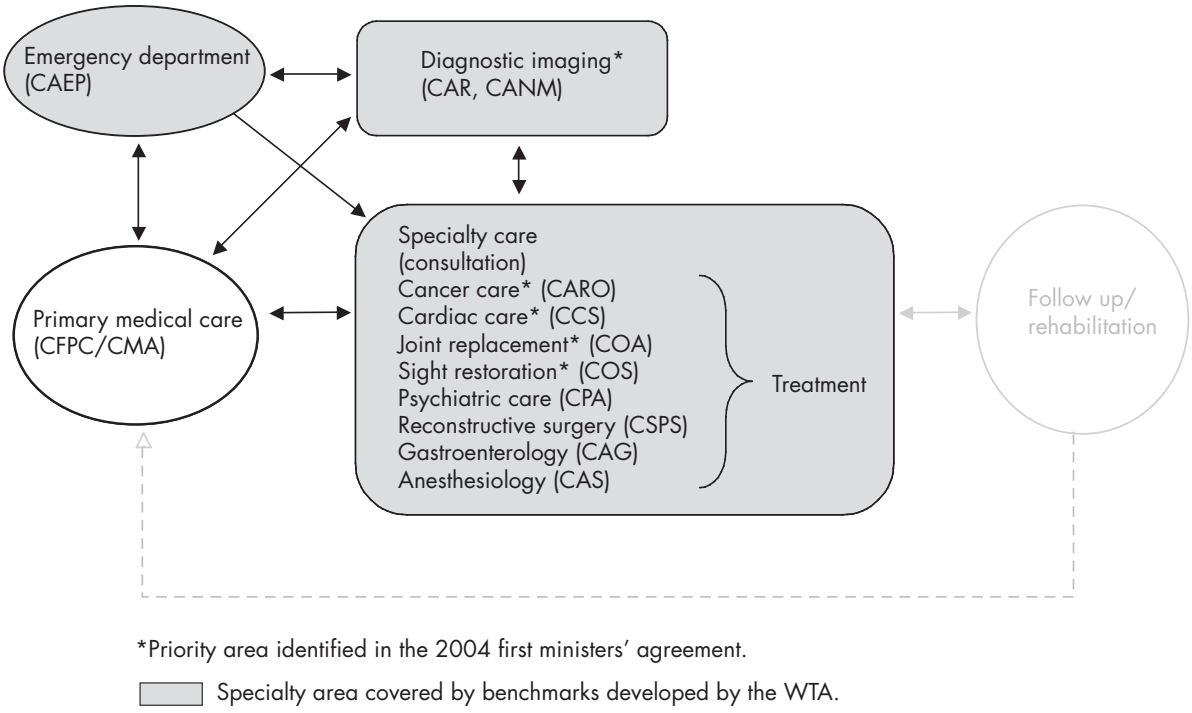
1. Canadians have a right to timely and high-quality care, beginning with access to a general practitioner or family physician (GP/FP). The achievement and maintenance of wait-time benchmarks *should in no way compromise the quality of care* provided to patients.
2. Wait-time benchmarks must *be developed from the patient's perspective*. This requires monitoring wait times from the moment the patient first contacts the health care system for his or her condition through to diagnosis, treatment and rehabilitation. Patients must also be involved in the development of wait-time benchmarks and be informed of approved wait-time benchmarks.
3. The development and setting of wait-time benchmarks should be based on a *pan-Canadian approach* to help ensure that Canadians receive comparable access to necessary care, avoid duplication of effort and maximize economies of scale. Although benchmarks should be pan-Canadian, targets may be set at the provincial or territorial level recognizing the different needs and capacities of provinces and territories to achieve the wait-time benchmarks.
4. Wait-time benchmarks should be *based on the best available evidence along with clinical consensus* (general agreement among the practising medical community) — both suitable to the Canadian context.
5. Wait-time benchmarks are dynamic and should be derived from *an ongoing and transparent process* that involves evaluation, timely updating and refinement when necessary. This process should include the ongoing evaluation of new technologies and their potential impact on wait-time benchmarks.
6. Successful development, improvement and implementation of wait-time benchmarks require the early, ongoing and *meaningful input of the practising community* (front-line health care workers).

7. *Public accountability*, through the monitoring and reporting of wait-times, is exceedingly important to maintain patients' confidence in the health care system. Reducing wait times for health services in the 5 priority areas would enhance confidence in the health care system.
8. Wait-time benchmarks and any associated provincial targets to reduce wait times must be *sustainable*. This will require a commitment to ongoing targeted funding through the Wait Times Reduction Fund and strategies to promote the appropriate use of health services.
9. The development of wait-time benchmarks for the 5 priority areas *must not be achieved at the expense of reduced access to other health care services*. Monitoring must be in place to ensure this does not happen.
10. Wait-time benchmarks must be *implemented with the use of appropriateness guidelines and prioritization tools that are fair, equitable and transparent to the patient*.

The benchmarks are presented under the 3 urgency categories used in previous WTA reports: emergency, urgent, scheduled. Given that emergency care targets pertain only to emergency situations, all benchmarks in this are under 1 category. Also, the target time for "urgent" for 1 specialty might differ from another because of the nature of the various illnesses.

As noted in its 2005 report on wait-time benchmarks for the initial 5 priority areas, the WTA views its benchmarks as "health system performance goals that reflect a broad consensus on medically reasonable wait times for health services delivered to patients."[5] Moreover, these benchmarks or performance goals are not intended to be standards and should not be interpreted as a line beyond which a health care provider or funder has acted without due diligence.[8] Every patient is unique and has different care needs. Also, wait-time benchmarks should not be regarded as carved in stone; rather, they will evolve with the advent of new research evidence, changes in technology and population health needs.

Figure 1: Framework for wait-time benchmark development.



Note: CAEP = Canadian Association of Emergency Physicians, CAG = Canadian Association of Gastroenterology, CANM = Canadian Association of Nuclear Medicine, CAR = Canadian Association of Radiologists, CARO = Canadian Association of Radiation Oncologists, CAS = Canadian Anesthesiologists' Society, CCS = Canadian Cardiovascular Society, CFPC = College of Family Physicians of Canada, CMA = Canadian Medical Association, COA = Canadian Orthopedic Association, COS = Canadian Ophthalmologists' Society, CPA = Canadian Psychiatric Association, CSPS = Canadian Society of Plastic Surgeons.

Table 1: Summary sample of wait-time benchmarks by priority level*.

Specialty and procedure	Wait-time benchmark		
	Emergency cases	Urgent cases	Scheduled cases
Emergency care	Level 1: Immediate (e.g., cardiac arrest) Level 2: < 15 min (e.g., chest pain) Level 3: < 30 min (e.g., moderate asthma) Level 4: < 60 min (e.g., minor trauma) Level 5: < 120 min (e.g., sprains)	Not applicable	Not applicable
Psychiatric care (e.g., psychosis, mania, major depression)			
• Access to family practitioner for acute mental health concerns	As deemed appropriate after triage	Within 24 h	Within 1 week
• Access to psychiatrist after referral by family physician	Within 24 h	Within 1–2 weeks	Within 2–4 weeks
Plastic surgery	Within 24 h (e.g., infections, burns, hand and facial trauma)	Within 2–8 weeks (e.g., most malignant neoplastic conditions, some craniofacial conditions)	Within 2–6 months (e.g., congenital anomalies, wounds, most elective hand procedures)
Gastroenterology (includes time from referral to consultation and/or treatment/procedure when indicated)	Within 24 h (e.g., acute gastrointestinal bleeding, acute severe hepatitis)	Within 2 weeks (e.g., high likelihood of cancer, painless obstructive acute jaundice) Semi-urgent: Within 2 months (e.g., iron-deficiency anemia, chronic diarrhea)	Within 6 months (e.g., screening colonoscopy, chronic gastroesophageal reflux disease)
Anesthesiology — pain management (wait time for first assessment by pain subspecialist after referral by primary physician)	See Table 8.		

*Priority or urgency levels are defined as follows: emergency = immediate danger to life, limb or organ; urgent = situation is unstable and may deteriorate quickly resulting in an emergency admission; semi-urgent = situation involving some pain, dysfunction and disability but patient is stable and unlikely to deteriorate quickly to the point of needing emergency care; scheduled = situation involving minimal pain, dysfunction or disability (also called "routine" or "elective").

Emergency care

The issues

For many Canadians, emergency departments continue to be a major point of access to the health care system, with approximately 10 million visits annually. The addition of emergency care wait-time benchmarks to the WTA model is an important development for 2 reasons. First, emergency departments are frequently viewed as a highly visible indicator of the state of Canada's health care system, particularly in terms of access and waits. Second, some emergency department patients are admitted to hospital and go on to surgery, which can affect surgical wait times and the use of scheduled resources.

Overcrowding in emergency departments is the most serious issue facing emergency care in Canada, as it results in increased patient suffering, prolonged wait times and deteriorating levels of service. One of the most common myths about overcrowding is the idea that it is caused by people with non-urgent conditions who clog up the system. In fact, non-urgent use of emergency departments has little effect on wait times. Such patients typically require minimal nursing care and do not occupy acute care stretchers.

The principal cause of overcrowding is the shortage of

beds in hospital wards and intensive care units. This leads to the "warehousing" of overflow patients in emergency departments, creating a situation where severely ill patients are "blocked" from access to timely care.[9] Acute care bed capacity is, in turn, significantly affected by the need for "alternative level of care" beds; approximately 20% of patients occupy acute care beds unnecessarily because of inadequate community resources and shortages of chronic-palliative care beds. On average, 1 patient "warehoused" in an emergency department prevents access by 4 patients an hour, directly contributing to prolonged wait times and patient suffering.[10]

Emergency department wait-time benchmarks

Representing 1800 emergency care physicians, the Canadian Association of Emergency Physicians (CAEP) plays a vital role in the development of national emergency standards and clinical guidelines. CAEP first developed medically acceptable wait-time guidelines (benchmarks) in 1998 as part of the Canadian triage and acuity scale (CTAS). The objectives of CTAS are to "more accurately define patients' needs for timely care and to allow emergency departments to evaluate their acuity level, resource needs and performance against certain operating 'objectives.'"[11] Physician response time for CTAS levels 1 and 2 is based on scientific evidence. For all other levels, it is based on physician expert opinion and consensus. The response times are ideals, or objectives, not established care standards.[12]

Patients are assigned to 1 of 5 categories on initial registration in the emergency department, based on the perceived urgency of their presenting complaint (Table 2). The admission rate refers to what one would expect based on the level of acuity or CTAS level.

In addition, CAEP has set wait-time targets for total length of stay in the emergency department (Table 3). Length of stay begins when the patient is first registered or triaged and ends when the patient physically leaves the emergency department.

CTAS is currently used and monitored in approximately 80% of Canadian emergency departments. Information monitored includes wait time to triage, time to be seen by a nurse, time to be seen by a physician, time to admission and time to transfer to a department. However, many hospitals still do not use a common computerized system for recording emergency department activity.

How are Canada's emergency departments faring in meeting these wait-time benchmarks? Although some information can be found for other provinces, comprehensive data are currently available only for Ontario.[13] In 2005, CIHI released a report based largely on Ontario hospitals (Table 4). As can be seen, for "less urgent" and "non urgent" levels, the median time (50% of patients) to initial assessment by a physician falls below the CAEP benchmarks. Similarly, the median wait for length of stay in the emergency department falls below the benchmarks for all levels. However, there is considerable room for improvement for both time to receive an initial physician assessment and overall length of stay in the emergency department when considering treatment time for 90% of the population as the actual wait times fall well above the CAEP targets for almost all levels.

An analysis of trends in emergency department use in Canada suggests that demand is changing, but is not expected to subside:

> Although the overall number of ED visits in Ontario has not changed dramatically over the last decade, the aging population and evolving patterns of healthcare utilization, especially among

Table 2: Triage levels and wait-time benchmarks for emergency department care.

CTAS level	Level of illness/ acuity	Physician response time; min	Sentinel diagnosis	Admission rate; %
1	Resuscitation	Immediate	Cardiac arrest	70–90
2	Emergent	< 15	Chest pain	40–70
3	Urgent	< 30	Moderate asthma	20–40
4	Less urgent	< 60	Minor trauma	10–20
5	Non urgent	< 120	Sprains	0–10

CTAS = Canadian triage and acuity scale.

Table 3: Benchmarks for length of stay in the emergency department.

CTAS level	Length of stay in the emergency department
1, 2 and 3	Not to exceed 6 h in 95% of cases
4 and 5	Not to exceed 4 h in 95% of cases
All admitted patients	Transferred out of the emergency department to an inpatient area within 2 h of decision to admit

CTAS = Canadian triage and acuity scale.

the elderly, is being reflected in increasing ED visit rates by those over the age of 55, and particularly over the age of 75. Such patients are generally much more complex to care for in EDs, as they often have multi-system disease.[14]

In addition to developing appropriate wait-time benchmarks, CAEP has recommended several strategies for improving access in emergency departments, including increasing the number of acute care beds, optimizing bed management strategies to improve appropriate use and implementing accountability measures. The United Kingdom has taken such an approach to reduce length of stay in its emergency departments. The country has adopted a target of 4 hours from arrival to admission, discharge or transfer. To support this target, financial incentives, accountability measures and increased investments in medical personnel and equipment were made. As a result, 96% of patients now spend 4 hours or less in emergency departments in the UK.

CAEP has recommended that Canadian governments adopt the CTAS guidelines as the standard wait-time benchmarks for Canadian emergency departments. In addition, each jurisdiction should establish a working group to investigate and address challenges associated with meeting the CTAS emergency department guidelines. Ideally, real-time Web-based collection of data on lengths of stay in emergency departments and times to admission should be put into place.[14]

Psychiatric care

The issues

Mental health has often been neglected in any major health effort in this country. In fact, Canada is the only industrialized country not to have a national strategy or plan regarding mental health. It should be no surprise, then, that mental health was not addressed in the first ministers' 10-year plan.

This lack of attention to mental health comes despite the facts that

- about 20% of Canadians will experience mental illness at some point in their life[15]
- 5 out of 10 leading causes of disability are now related to mental disorders
- mental health conditions now contribute more to disability in Canada than any other single disease group, including cancer, diabetes and cardiovascular disease[16]
- more people die by suicide than from motor vehicle accidents. Most people who die by suicide have some history of psychiatric illness — and those who die by suicide are disproportionately young
- untreated depression is the greatest cause of disability in women of working age.

Timely access to psychiatric health services remains a serious challenge. Wait lists for mental health services are seldom maintained, as the gap between need and availability of treatment is too large. In fact, the 2004 National Physician Survey found that access to psychiatrists by family physicians on behalf of patients was much more difficult than for any other category of specialized medicine, with 65% of family physicians reporting serious difficulties in getting access to mental health specialists.[17]

Fortunately, attention to the need for a better mental health system has been heightened by the 2006 release of the report of the Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*,[18] and the newly established Mental Health Commission headed by the Honourable Michael Kirby.

Table 4: Physician response time and length of stay in the emergency department, 2003–2004.

	Time to initial assessment by physician; min		Length of stay in emergency department	
CTAS level	CAEP/WTA benchmark	Actual time; min median (and treatment time for 90% of patients)	CAEP/WTA benchmark; min	Actual time; min median treatment time (and for 90% of patients)
1 (resuscitation)	Immediate	5 (45)	360	161 (544)
2 (emergent)	<15	36 (129)	360	241 (638)
3 (urgent)	<30	60 (186)	360	190 (510)
4 (less urgent)	<60	54 (163)	240	100 (275)
5 (non-urgent)	<120	40 (135)	240	67 (194)

Source: CIHI.[13] Data are from 163 Ontario emergency departments, 4 sites in Nova Scotia, 3 sites in British Columbia and 1 in Prince Edward Island.

The Canadian Psychiatric Association (CPA) is the national voice for Canada's 4100 psychiatrists and more than 600 psychiatric residents. Although psychiatric services were not included in the first ministers' initial 5 priority areas, the CPA developed wait-time targets, citing the poor access Canadians experience for psychiatric care: "If clinicians do not establish appropriate targets themselves, then no service can be evaluated against good clinical criteria."[19]

Wait-time benchmarks for psychiatric care

As was done for the original 5 priority areas, the CPA chose to identify wait-time benchmarks or performance goals for sentinel conditions (Table 5).

First, illnesses were chosen that were clearly outside the realm of everyday emotional states, i.e., conditions that could readily be identified as illnesses. For the 1 illness for which there may be some potential confusion with normal emotional responsiveness (severe major depressive illness), the intervening variable of an evaluation by a family practitioner was recommended.

Second, literature regarding the effects of duration of untreated illness was reviewed with particular reference to the relation between this duration and the future rehabilitative potential and ease of recovery for patients with the illnesses.

Third, a small group of senior clinicians considered all of the information to arrive at reasonable consensus based guidelines.

The proposed guidelines were then circulated widely in an iterative process, first to specialists in each of the illnesses, then to academic departments of psychiatry and finally to the members of the Canadian Psychiatric Association. The consensus document was then circulated for comment to other professional groups as well as organizations representing patients and their families.

The benchmarks represent the best medical estimate for appropriate wait times from referral to first contact for the clinical conditions in question. They should be distinguished from figures published by the Fraser Institute, which focused on another very important waiting period: how long does it take, after seeing the specialist, to get into a specific program of treatment.

The guidelines also differ from figures published by el-Guebaly and Atkinson in 2001,[20] which did not address specific conditions, but rather general access. The classification of "emergent, urgent, routine and elective" used by these authors differs from the more standardized ones suggested by the WTA and used in the CPA recommendations.

Although identification of medically appropriate wait times is important, barriers preventing access to care are significant. Epidemiologic surveys show that many people who suffer do not seek care at all. Attempted or completed suicide may be the first presentation of a depressive illness; for a high proportion of sufferers from schizophrenia, the first presentation may involve contact with the police, at the request of a friend or relative. One of the greatest barriers is stigma — the shame felt by patients who suffer from a "mental illness," often coupled with the attitude of disinterest or rejection conveyed by health care workers in offices, clinics, hospitals and emergency rooms.

The CPA acknowledges that there are many identifiable waiting periods in the overall care process, including the wait for access to hospital care and the wait for rehabilitative therapy and proper community support. The CPA also acknowledges the important role played by family physicians in the care process. Not all psychiatric conditions require specialist care. The wait time starts when the patient and the physician both decide that a referral is needed; however, this is based on the assumption that the patient has easy access to a family practitioner. As a result, the CPA has identified 1 benchmark specifically related to

Table 5: Recommended wait-time benchmarks for psychiatric care.

Indication	Emergent	Urgent	Scheduled
Access to family practitioner			
Acute or urgent mental health concerns	As deemed appropriate after triage	Within 24 h	Within 1 week
Access to psychiatrist after referral by family physician			
First episode psychosis	Within 24 h	Within 1 week	Within 2 weeks
Mania	Within 24 h	Within 1 week	Not generally applicable
Hypomania, with previous diagnosis of mania	Not generally applicable	Within 2 weeks	Within 4 weeks
Postpartum severe mood disorder or psychosis	Within 24 h	Within 1 week	Within 4 weeks
Major depression	Within 24 h	Within 2 weeks	Within 4 weeks
Diagnostic and management consultation (including consultations for child and geriatric conditions not otherwise noted above)	Within 24 h	Within 2 weeks	Within 4 weeks

access to a family practitioner for acute or urgent mental health concerns whereas the remaining benchmarks are related to access to a psychiatrist on referral by a family physician.

Few data are available on wait times for psychiatric services in Canada. Many clinicians do not maintain wait lists for a variety of reasons related to the overwhelming pressures within psychiatric care and the fact that in many cases, there are very few services available.

> One in five Canadians will experience a significant episode of mental illness over the course of their lifetime. Yet, it has been estimated that only one third of the people who could benefit from professional consultation for mental health issues actually get to see someone who could help them. Can you imagine the public outcry if this were the case with any other illness — if, say, only one third of the people needing cancer treatment actually received it![21]

A sample survey conducted by the CPA in 2001,[20] found that the median wait for non-emergent psychiatric treatment was 7.5 weeks. This is supplemented by anecdotal reports from psychiatrists. Information provided to the Standing Senate Committee on Social Affairs, Science and Technology looking into the state of mental health, mental illness and addiction indicated that the waiting list for children and youth for a psychiatric consultation ranged from 8 weeks to18 months.[22] There are also anecdotal reports that an increasing number of psychiatrists are no longer accepting patients for waits beyond 8 months because of liability concerns — hence removing more patients from the lifeline that offers some comfort should the condition worsen. Access to psychiatric care remains a challenge particularly for rural and remote communities.

Although the CIHI collects data on psychiatric admissions to hospital, a data collection and reporting framework on access to community mental health services based on common indicators and data standards is required.

Plastic surgery

The issues

Plastic surgeons in Canada provide a wide spectrum of acute and scheduled medically necessary surgical services. Plastic surgeons rebuild bones and soft tissue of legs and other body parts after devastating accidents and cancer surgery. They also treat a large number of Canadians with skin cancer and repair all types of facial defects, such as cleft lips. A plastic surgeon is specifically qualified to practise reconstructive and esthetic plastic surgery.

The Canadian Society of Plastic Surgeons (CSPS) — the professional body for plastic surgeons in Canada — has become increasingly concerned about patients' access to plastic surgery as wait times lengthen. A comparison of wait times for plastic surgery between 1993 and 2005 conducted by the Fraser Institute found that total wait times from referral to surgery increased from 5.9 weeks in 1993 to 15.4 weeks in 2005. In fact, wait times for plastic surgery have become the second lengthiest of all specialties.[23]

Table 6: Summary of benchmarks for plastic surgery.

Medical condition (reconstructive surgery)	Wait-time benchmark (80% consensus)
Acute conditions	
• Nasal fracture	1–2 weeks
• Major burn	2–4 days
• Hand trauma (flexor tendon laceration)	4–7 days
• Replantation (digit)	6–12 h
Breast related conditions	
• Breast reconstruction (immediate)	2–4 weeks
• Breast reconstruction (delayed)	6–9 months
Congenital anomalies	
• Cleft lip	2–4 months
• Cleft palate	9–12 months
• Craniofacial anomaly	9–12 months
Eyelid surgery	
• Ptosis (levator weakness)	4–6 months
Elective hand procedures	
• Carpal tunnel syndrome with permanent numbness	1–2 months
Malignant neoplastic conditions	
• Lesion suspicious for melanoma	2–4 weeks
Benign neoplastic conditions	
• Diabetic foot ulcer	2–4 months
• Non-healing wound	2–4 months

Wait-time benchmarks for plastic surgery

In response to increasing wait times, the CSPS initiated a process to determine acceptable benchmarks for the full range of plastic surgical procedures. It began this process with a MEDLINE search that revealed that little work on wait-time benchmarks for plastic surgery has been done worldwide. In the absence of clinical trial research, expert opinion represents the best method for developing wait-time benchmarks.

To strengthen the process of determining wait-time benchmarks, a steering committee of CSPS went beyond committee

consensus and conducted an electronic survey of all its members who had provided an email address. A 66% response rate was achieved among a sample size of 266 members. The survey solicited expert input on a comprehensive range of 91 plastic surgery procedures. Respondents were asked to select the period that "corresponds to the maximum wait time that you feel is acceptable between referral and surgery." The selected wait-time benchmark was the period for which 80% of respondents felt that patients should wait. Although the high response rate assures that the findings represent national consensus among plastic surgeons in Canada, it should be noted that these maximum wait times are conservative thresholds — plastic surgeons would prefer not to see their patients wait this long.

The CSPS specialty report lists the wait-time thresholds for all 91 conditions organized by medical condition (not by urgency) to illustrate the diverse range of conditions included in the benchmarking process. Table 6 provides a summary. A complete list of benchmarks can be found on the WTA Web site.

Acceptable wait times for most cosmetic surgical procedures (e.g., mole and blemish removal, liposuction, tattoo removal) are 12–18 months.

Provincial wait-time Web sites report on plastic surgery wait times in British Columbia, Alberta, Saskatchewan and, to a limited extent, New Brunswick and Nova Scotia. However, the data provided are neither consistent nor comparable among provinces. One survey of plastic surgeons in Canada estimated the current wait time for a nonurgent plastic surgery procedure at 8 months.[24]

Long surgical waits and their effect on patient well-being have been a growing concern among plastic surgeons. The causes of increasing waits for plastic and reconstructive surgery are multifactorial and include, but are not limited to, population aging and growth, diminishing health care resources (including lack of operating room time) and fewer HHRs.

A 2004 survey of Canadian plastic surgeons found that 78% felt that there was a shortage of plastic surgeons in their community. Furthermore, 28% of respondents indicated that they plan to retire within the next 5 years. The biggest factors contributing to the shortage of plastic surgeons include early retirement and more time spent in noninsured arenas.[24] Access to plastic surgeons is particularly limited in rural regions. Consequently, a sustained, national approach to the training of plastic surgeons is required in Canada to ensure adequate patient access in the future.

Gastroenterology

The issues

Gastroenterology care refers to the treatment of illnesses and disorders affecting the digestive system. Although gastroenterologists have made significant advances in the study of digestive diseases and their treatment, the health and economic burden of digestive diseases remains significant. For example, 12% of all admissions to hospital are for treatment of digestive diseases.[25] Common reasons for referral to a gastroenterologist include gastrointestinal bleeding, colon cancer screening, abdominal pain, dyspepsia, irritable bowel syndrome, inflammatory bowel disease and diarrhea.

The Canadian Association of Gastroenterology (CAG), comprising over 1000 members from various disciplines — physicians, surgeons, pediatricians, radiologists and basic scientists — is actively involved in research, education and patient care in all areas of digestive health and disease. CAG members have expressed growing concern over increasing wait times for gastroenterology.

CAG has undertaken several initiatives to address wait-time problems including:

- a practice audit in which 200 gastroenterologists captured national data on 5500 patient visits over 6 months
- an HHR analysis of gastroenterologists in Canada
- development of maximum wait-time targets for both referral and treatment.

Wait-time benchmarks for gastroenterology

A rigorous consensus-based approach was followed by CAG to develop wait-time targets. The process was overseen by a steering committee of community and academic gastroenterologists from across Canada.[26] The committee conducted an extensive literature review and a patient survey at selected sites across the country. Based on this data (level III), a modified Delphi approach was followed for proposed maximal wait-time targets for 27 conditions. The statements were circulated to a multidisciplinary committee representing national and regional gastroenterology associations, general surgery, internal medicine and family practice. The committee subsequently reached a consensus on 24 wait-time targets or benchmarks for adult patients that fall under 4 urgency categories from referral to endoscopy (Table 7). These benchmarks include the time from family physician referral to the gastroenterologist as well as the wait to receive endoscopy — a measure unique to this specialty.

A complete list of benchmarks can be found on the WTA Web site. Another unique feature of these targets compared with those of most other specialties is that they deal primarily with symptoms or signs that remain undiagnosed.

Not only has CAG identified wait-time targets for gastroenterology services, but it has also collected data on

how Canadians are faring when it comes to accessing gastroenterology services. The results are troubling.

- 50% of patients referred by a family physician wait more than 2 months to see a gastroenterologist; 20% of patients wait more than 4 months.
- Once seen by a gastroenterologist, 50% of patients must wait another 6 weeks for a diagnostic test; 20% wait nearly 4 months.

In most instances, wait times for consultation and endoscopic services far exceed established targets for all areas of digestive disease. Of major concern is the mounting demand for gastroenterology services for colon cancer screening. Many regions and provinces have or are launching colon cancer screening programs to prevent the second most common cancer among Canadians. Although such programs are essential and welcome, wait times will only worsen in response to these demands.

Table 7: Recommended wait-time benchmarks for gastroenterology (from referral to endoscopy).

Within 24 h (emergency) - Acute gastrointestinal bleeding - Esophageal food bolus or foreign body obstruction - Clinical features of ascending cholangitis - Severe acute pancreatitis - Severe decompensated liver disease - Acute severe hepatitis
Within 2 weeks (urgent) - High likelihood of cancer based on imaging or physical examination - Painless obstructive acute jaundice - Severe or rapidly progressive dysphagia or odynophagia - Clinical features suggestive of active inflammatory bowel disease
Within 2 months (semi-urgent) - Bright red rectal bleeding - Documented iron-deficiency anemia - One or more positive fecal occult blood tests - Chronic viral hepatitis - Stable dysphagia (not severe) - Poorly controlled reflux/dyspepsia - Chronic constipation or chronic diarrhea - New onset change in bowel habit - Chronic unexplained abdominal pain - Confirmation of a diagnosis of celiac disease (antibody test)
Within 6 months (scheduled screening) - Chronic gastroesophageal reflux disease for screening endoscopy - Screening colonoscopy - Persistent unexplained abnormal liver enzyme tests

Source: Paterson et al.[26]

Access to gastroenterologist care can vary across the country. In Ontario in 2005, 20% of patients with alarm symptoms — symptoms that raise the possibility of diseases such as cancer — waited over 20 weeks from initial referral to procedure or tests; 25% of patients in British Columbia, Alberta and Quebec waited over 16 weeks.[27]

The principal causes of lengthy delays for gastroenterology services are a shortage of gastroenterologists and limited access to facilities, such as hospital suites for diagnostic services. CAG's HHR analysis of gastroenterologists raises several critical concerns. For instance, 18% of Canadian gastroenterologists are 60 years of age or older and about a third are expected to retire within 10 years.[28] As it now stands, Canada's supply of gastroenterologists is low compared with other countries — 1.83 gastroenterologists per 100 000 population compared with 3.90 in the United States.

Anesthesiology

The issues

During the WTA's work, the availability of anesthesiologists has been raised repeatedly as a critical factor in reducing lengthy surgical wait times. Anesthesiologists are vital members of the surgical team, responsible for keeping patients safe and comfortable during and after the operation. They also provide care in other areas of the hospital including intensive care units, pre-admission consult clinics and labour rooms for obstetrics. A United Kingdom study estimated that anesthesiologists are involved in the care of two-thirds of all patients admitted to hospital.[29]

Table 8: Recommended benchmarks for anesthesiology.

Condition	Wait time for first assessment by pain subspecialist after referral by primary physician*
Acute neuropathic pain of less than 6 months' duration	30 days
Acute lumbar disc protrusion	3 months
Cancer pain†	14 days
Subacute chronic pain in an adult of working age where intervention may improve function	3 months
Other types of chronic pain	6 months

*Does not include subsequent waits for rehabilitation programs, psychology-based programs or interventional procedures that may be deemed appropriate after the initial consultation.
†Service within 14 days is recommended for patients who do not have access to a palliative service or in cases in which a palliative care team has asked for a specific procedure.

Who is an anesthesiologist?

The term anesthesiologist describes all licensed medical practitioners with privileges to administer anesthetics. Anesthesia is any procedure that is deliberately performed to render a patient temporarily insensitive to pain or the external environment, so that a diagnostic or therapeutic procedure can be performed. [30] Canadian anesthesiologists are physicians who have completed a university premedical program, followed by medical school and 5 or more years of specialized residency training in anesthesiology.

The wait-times reduction agenda for many surgical procedures cannot proceed unless there is an adequate supply and effective utilization of a range of resources including anesthesiologists. Anesthesiology is a specialty that is often overlooked when it comes to HHR issues and planning; however, the appropriate supply and utilization of anesthesiologists and related resources must be addressed if we want to avoid cancellations, delays and, ultimately, longer waits times for many medical services. Related resources include critical care beds and the necessary nurses to staff the beds.

The WTA invited the Canadian Anesthesiologists Society (CAS) to join its ongoing work to provide wait-time benchmarks in the area of pain management and serve as a member of the surgical team supporting the other specialties to provide timely care.

Pain management benchmarks

Many patients with chronic pain can be treated effectively by their family physician using treatments that include medications available in the community. Many family physicians are reluctant to prescribe medications with proven efficacy in alleviating chronic pain (e.g., they may be concerned about the risk of addiction associated with the use of opioids). If family physicians were given proper training in the treatment of chronic pain and adequately remunerated for the extra time that is often required to care for patients with chronic pain, the burden on pain clinics would be reduced and many patients would have a better quality of life.

The Canadian Pain Society reviewed the evidence concerning acceptable wait times for the treatment of chronic pain at multidisciplinary pain centres. [31] The CAS examined its findings and held informal consultations with anesthesiologists who are directors of pain clinics. The results indicate that there may be a marked decline in function in patients who suffer chronic pain for more than 6 months. The society recommends that patients wait no longer than 6 months from the time of referral by their primary physician to their first assessment by a subspecialist in chronic pain management, with the proviso that shorter wait times should be established for certain conditions for which early intervention may be particularly beneficial (Table 8). Because of a lack of resources, many chronic pain subspecialists currently have long wait lists and may not be able to provide services within the recommended time intervals.

Tremendous advances in the practice of anesthesiology have taken place over the past 2 decades as a result of developments in the education and training of anesthesiologists, an expanded knowledge base and remarkable innovations in equipment, technology and pharmacotherapeutics. More complex surgical cases are now done on an older and higher-risk patient population with significant medical comorbidities. The increasing surgical load imposes severe strains on the ability of anesthesiologists to meet their clinical and academic obligations. The CAS is searching for ways to improve the efficiency of anesthesiologists while maintaining or enhancing quality of care.

Given this background, the concept of anesthesia assistants is endorsed by the CAS; the CAS welcomes the addition of competent, well-trained health care professionals to assist in the delivery of anesthetic care in the operating room. The 1-to-1 relationship between anesthesiologist and anesthetized patient would remain. A model of an anesthesia care team already exists in Quebec, where anesthesia assistants aid in the delivery of anesthesia care within guidelines clearly defined in the code of professions. In Ontario, the Michener Institute for Applied Health Sciences is delivering the first educational program for anesthesia assistants.

In 2005, the Michener Institute received funding from the Ministry of Health and Long Term Care to develop the anesthesia assistants program specifically for respiratory therapists and registered nurses. The two groups were identified as ideal candidates for the role because of their similar delegated responsibilities in hospitals and their prior exposure to patient management. The anesthesia assistants program began in January 2006 and focuses on general anesthesia, regional anesthesia and conscious sedation. During the 22-week program, a combination of theoretical education, simulated training and clinical placements provide students with the competencies needed to troubleshoot anesthesia equipment, assist in preparing patients for surgery and effectively monitor patients' vital signs during and after surgical procedures.

The introduction of anesthesia care teams opens the door to more effective utilization of the anesthesiologists' time by allowing them to delegate some tasks to other members of the team. This signifies an important change in public health care with the potential to improve wait times for surgical procedures and to increase the number of patients receiving surgical care.

Key issues and recommendations

This report is another installment in the WTA's ongoing commitment to reduce lengthy wait times beyond the 5 priority areas announced in the first ministers' 10-year plan. Wait-time benchmarks have now been produced by 5 more medical specialties (emergency care, psychiatric care, plastic surgery, gastroenterology and anesthesiology).

The benchmarks listed in this report represent a considerable amount of work, expertise, reflection and consultation by members of the medical community. Like the initial set of benchmarks identified by the WTA in 2005, these newly proposed national benchmarks are sound and attainable. However, it cannot be stressed enough that these benchmarks should not be construed as standards. For the most part, they should be viewed as maximum acceptable wait times, not ideal wait times.

Generating these benchmarks has been a positive effort that has fostered healthy discussion among medical specialties on various strategies that can be implemented to improve timely access to care. A common theme in the specialty reports is the current and forecast shortage of specialists. Although the prescription for honouring the wait-time benchmarks requires a number of steps, it must begin with addressing shortages of HHRs, not only among the specialties covered by benchmarks but among others, including family physicians, and among other health care providers, such as nurses and technicians. That is why the WTA has consistently called for a pan-Canadian HHR strategy based on the principle of self-sufficiency for Canada.[2] The *Framework for Collaborative Pan-Canadian Health Human Resources Planning* prepared by the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources represents a start toward achieving this goal.[32]

Although Canada's dire shortage of HHRs remains the biggest challenge to improving timely access to care, the specialties featured in this report have also made the case that physical infrastructure gaps need to be addressed. These gaps include acute care and alternative level of care beds, operating theatres and diagnostic suites, and community services. For example, although emergency departments may take steps to streamline their services and use their staff in the most efficient and effective manner possible, they will be unsuccessful in significantly reducing their wait times without an adequate supply of inpatient and alternative level of care beds and community supports. A system-wide approach is required.

The WTA's work over the past year has highlighted the lack of standardized data for monitoring progress as a key issue in the wait-times reduction agenda in Canada. Wait-time data are captured and reported differently across the country making monitoring and cross-jurisdiction comparisons extremely difficult. In addition, jurisdictions start counting wait-times at different points, which can often lead to distorted pictures of the time a patient actually waits. Clearly, it will be a challenge to measure and monitor new wait-time benchmarks when we have thus far been unable to do this accurately for a select few. Greater effort is required by all parties to capture wait-times data to determine with greater certainty whether any progress is being made, given the sizeable funding allocations provided by governments.

Next steps

There are 2 key milestones on the horizon regarding wait-time benchmarks and the commitments pertaining to the first ministers' 2004 health accord or 10-year plan. First, the plan calls for provinces and territories to announce multiyear targets for meeting the wait-time benchmarks by Dec. 31, 2007. Although some jurisdictions are operating on the basis that the benchmarks are now in effect, for most it is not clear how and when they will take effect. Therefore, the WTA expects to see announcements from provinces and territories on this matter between now and the end of the year.

The second milestone is a review of the 10-year plan itself. The federal legislation passed to implement the plan's funding commitments provides for Parliamentary reviews to assess progress in 2008 and 2011. The WTA will be an active participant in the upcoming spring 2008 review by releasing another report card on progress toward improving access to timely care for Canadians.

Recommendations

Based on its work in the development of wait-time benchmarks, the WTA recommends:

1. With respect to meeting the commitments agreed to in the first ministers' 10-year plan,
   i. Governments accept all outstanding wait-time benchmarks outlined in the WTA's 2005 report, *It's About Time*, that have not yet been adopted (i.e., cardiac care and diagnostic imaging)
   ii. Governments announce multiyear targets for meeting wait-time benchmarks in the initial 5 priority areas by Dec. 31, 2007.
2. With respect to patient wait-time guarantees for the initial 5 priority areas,
   i. Provincial governments adopt patient wait-time guarantees for each of the initial 5 priority areas by Dec. 31, 2007, that involve a publicly funded method of recourse for patients facing waits that exceed benchmark thresholds
   ii. Provincial governments standardize the conditions of their patient wait-time guarantees to ensure comparable guarantees for all Canadians
   iii. Governments issue regular progress reports (e.g., semi-annual) on the status of implementing their patient wait-time guarantees.
3. With respect to the WTA's new wait-time benchmarks,
   i. Governments adopt the new wait-time benchmarks provided in this report on a pan-Canadian basis and begin to promote their use as part of an effort to move beyond the initial 5 priority areas
   ii. Where it has not yet occurred, governments expand their collection and reporting of wait-time data beyond the 5 priority areas
   iii. Federal government commit new funding to
      - assist provinces and territories to provide timely access to care for the services addressed under the new set of wait-time benchmarks including funding in the area of HHR
      - support the Canadian Institutes of Health Research in wait-time benchmark development research and the Canadian Institute for Health Information in the adoption of comparable wait-time data that accurately reflect the length of time patients wait for access to care.

Glossary

For the work of the WTA to be clear and consistent, it is important to agree up front on a set of common terms associated with the development and use of wait-time benchmarks.[5] Accordingly, the following definitions apply for the purposes of this report.

Benchmark — A reference point against which performance may be assessed.

Emergency — Immediate danger to life or limb.

Scheduled — Situation involving minimal pain, dysfunction or disability (also called "routine" or "elective").

Semi-urgent — Situation involving some pain, dysfunction and disability, but that is stable and unlikely to deteriorate quickly to the point of becoming an emergency

Urgent — Situation that is unstable and has the potential to deteriorate quickly and result in an emergency admission.

Wait time — There are multiple wait times involved in a health care episode, beginning with the wait to see a family physician or general practitioner. The patient's wait for specialty care begins at the point when he or she receives a differential diagnosis from the family physician/general practitioner and it is decided that the patient requires diagnostic testing or clinical intervention or both.

There can be discrepancies among jurisdictions and institutions as to when the wait time begins. For most cases, the wait time for specialty treatment should be from the date of referral by the specialist or a booking request is received by the facility to the day of treatment. In the case of radiation oncology, the wait time begins from the time the patient is ready to be treated to the date of the first treatment.

Wait-time benchmarks — Health system performance goals that reflect a broad consensus on medically reasonable wait times for health services delivered to patients. They are not intended to be standards nor should they be interpreted as a line that a health care provider or funder has crossed without due diligence. Wait-time benchmarks may be determined through a variety of means such as the performance of a peer group or by establishing time-based standards or percentage thresholds of activity within a patient population for a specified interval of time.

Wait-time indicator — Standardized measure of wait time for a given health service that is comparable across jurisdictions and provides an accurate picture of wait times for a cohort of patients. For example, the percentage of patients needing primary hip replacement who have waited more than 1 year for surgery.

Wait-time target —A wait time target is in effect for a given period of time and represents a step toward achieving a medically acceptable wait time for all patients. For example, jurisdiction X will aim to have 70% of patients needing primary hip replacement operated on within the benchmark wait time by 2007, moving up to 90% by 2009.

Appendix A: Wait Time Alliance benchmarks for the initial 5 priority areas

Summary of wait-time benchmarks by priority level*.

	Wait-time benchmark		
Specialty and procedure	**Emergency cases**	**Urgent cases**	**Scheduled cases**
Radiology (diagnostic imaging)			
• CT and MRI	Immediate to 24 h	Within 7 days	Within 30 days
Nuclear medicine (diagnostic imaging)			
• Bone scan (whole body)	Immediate to 24 h	Within 7 days	Within 30 days
• FDG-PET	Immediate to 24 h	Within 7 days	Within 30 days
• Cardiac nuclear imaging (perfusion; viability; LV function) (SPECT or PET)	Immediate to 24 h	Within 3 days	Within 14 days
Joint replacement			
• Hip and knee replacement surgery	Immediate to 24 h	Within 30 days (priority 1) Within 90 days (priority 2)	Consultation within 3 months Treatment within 6 months of consultation
Cancer care			
• Radiation therapy	Immediate to 24 h	Based on individual need	Consultation within 10 working days Treatment within 10 working days of consultation
Sight restoration			
• Cataract surgery	Not applicable	Cases are expedited proportional to relative degree of priority	Within 16 weeks of consultation
Cardiac care			
• Initial specialist consult	Immediate to 24 h	Within 7 days	Within 6 weeks
• Diagnostic procedures (diagnostic catheterization)	Immediate to 48 h	Within 3 days	Within 6 weeks
• Therapeutic services and procedures			
- Angioplasty	Immediate to 48 h	Within 7 days	Within 6 weeks
- Bypass surgery	Immediate to 48 h	Within 14 days	Within 6 weeks
- Valvular surgery	Immediate to 24 h	Within 14 days	Within 6 weeks
- Heart failure services	Immediate to 24 h	Within 14 days	Within 6 weeks
- Pacemaker	Within 3 days	Within 14 days	Within 6 weeks
- Referral to electrophysiologist	Not applicable	Within 30 days	Within 3 months
- Electrophysiology testing/catheter ablation	Not applicable	Within 14 days	Within 3 months
- ICD	Within 3 days	Not applicable	Within 8 weeks
• Cardiac rehabilitation	Immediate	Within 7 days	Within 30 days

Note: CT = computed tomography; FDG = fluorodeoxyglucose; ICD= implantable cardioverter defibrillator; LV = left ventricular; MRI = magnetic resonance imaging; PET = positron emission tomography; SPECT = single photon emission computed tomography.
Unless specified, time refers to calendar days between decision to treat by specialist and the day treatment is received.
*Priority or urgency levels are defined as follows: emergency = immediate danger to life, limb or organ; urgent = situation that is unstable and has the potential to deteriorate quickly and result in an emergency admission; scheduled = situation involving minimal pain, dysfunction or disability (also called "routine" or "elective").

Appendix B: Patient wait-time guarantees by province and territory (spring 2007)

Jurisdiction	Procedure/area	Guarantee*
Newfoundland and Labrador	Bypass surgery	• Within 26 weeks • To be implemented by 2010
Prince Edward Island	Radiation therapy	• Residents who are at risk of waiting longer than the 8-week time frame while considered "ready to treat" will be given the opportunity to receive timely access to radiation therapy at another public health institution within the Maritime region, Quebec and Ontario • To be implemented by March 31, 2010
Nova Scotia	Radiation therapy	• Within 8 weeks of being referred or will be given another option • To be implemented by 2010
New Brunswick	Radiation therapy	• Within 8 weeks, with access to alternate care options as required • To be implemented within the next 3 years
Quebec	Hip, knee and cataract surgery	• 6-month wait-time guarantee • Bill 33, which outlines how the guarantee is to apply, has not yet come into force
Ontario	Cataract surgery	• 26 weeks for cataract surgery (patients will be offered the surgery at another location within Ontario where they will not have to wait beyond the 26-week access target to receive their surgery) • To be implemented Jan. 1, 2009
Manitoba	Radiation therapy	• Within 4 weeks (patients offered alternative options for care if the common medically recommended benchmark time for the service is exceeded) • To be implemented by spring 2008
Saskatchewan	Bypass surgery	• Current pan-Canadian benchmarks for this procedure will be used: 2–26 weeks, depending on the identified level of urgency for each patient • Saskatchewan Health will work closely with regional health authorities, cardiac specialists and other health system partners to establish and implement a reasonable and responsible recourse for those who do not receive their cardiac bypass surgery within the guaranteed time frame
Alberta	Radiation therapy	• 8 weeks from ready to treat • Implemented by March 31, 2010
British Columbia	Radiation therapy	• By March 31, 2010, for residents who are at risk of waiting longer than the province's proposed timeframe of 8 weeks from the date a patient is ready for treatment • No details on what type of recourse will be available
Yukon	Mammography	• To be implemented by February 2010 • Details to follow
Northwest Territories	Primary health care	• To be implemented by March 2010
Nunavut	Diagnostic imaging (e.g., video assisted ultrasound)	• To be implemented by 2010

*Note: As part of their commitment to implement a wait-times guarantee, most provinces have announced that they will first conduct pilot projects to test out the concepts involved in implementing a guarantee before it takes effect.

Appendix C: Wait Time Alliance members

All specialty reports are located on the Wait Time Alliance Web site (www.waittimealliance.ca/index.htm)

Canadian Anesthesiologists' Society
208–1 Eglinton Avenue E
Toronto ON M4P 3A1
416 480-0602
www.cas.ca

Canadian Association of Emergency Physicians
104–1785 Alta Vista Drive
Ottawa ON K1G 3Y6
613 523-3343 or 800 463-1158
www.caep.ca

Canadian Association of Gastroenterology
2902 South Sheridan Way
Oakville ON L6J 7L6
905 829-2504
www.cag-acg.org

Canadian Association of Nuclear Medicine
774 Echo Drive
Ottawa ON K1S 5N8
613 730-6254
www.csnm.medical.org

Canadian Association of Radiation Oncologists
600 West 10th Avenue
Vancouver BC V5Z-4E6
604 877-6193
www.caro-acro.ca

Canadian Association of Radiologists
1740 Côte-Vertu Blvd
Saint-Laurent QC H4L 2A4
514-738-3111
www.car.ca

Canadian Cardiovascular Society
1403–222 Queen Street
Ottawa ON K1P 5V9
613-569-3407
www.ccs.ca/home/index_e.aspx

Canadian Ophthalmological Society
610–1525 Carling Avenue
Ottawa ON K1Z 8R9
613 729-6779
www.eyesite.ca/english/index.htm

Canadian Orthopaedic Association
360–4150 Sainte-Catherine Street W
Westmount QC H3G 1R8
514 874-9003
www.coa-aco.org/Frameset.html

Canadian Psychiatric Association
701–141 Laurier Avenue W
Ottawa ON K1P 5J3
613 234-2815 x236
www.cpa-apc.org

Canadian Society of Plastic Surgeons
4–1469 Saint-Joseph Boulevard E
Montréal QC H2J 1M6
514 843-5415
www.plasticsurgery.ca

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