Ensuring timely access to all medically necessary care

The WTA believes Canadians deserve timely access to a full range of medically necessary care, not just the 5 areas identified in the 2004 agreement. To that end, the WTA is pleased to report that 7 additional specialty care areas have developed benchmarks including emergency care, psychiatric care, plastic surgery, gastroenterology, anesthesiology, and obstetrics and gynecology.

Timely access to these other specialty care areas is often poor, as has been documented in some areas (e.g., gastroenterology). Unfortunately, due to a lack of provincially captured data, a grade assessment is not possible at this time for these additional areas. Federal and provincial/territorial governments need to adopt wait-time benchmarks for all areas of specialty care, and begin collecting and reporting patients' access for all medical services.

Summary of new WTA benchmarks*

	Emergency cases	Urgent cases	Scheduled cases
Emergency care (CTAS levels 1–5)	1: Immediate 2: < 15 min 3: < 30 min 4: < 60 min 5: < 120 min	Not applicable	Not applicable
Psychiatric care	Within 24 hrs	24 hrs to 1–2 wks	1–4 wks
Plastic surgery	Within 24 hrs	2–8 wks	2–6 mths
Gastroenterology	Within 24 hrs	2–8 wks	Within 6 mths
Anesthesiology (chronic pain)	See WTA's website for benchmarks for pain management		
Obstetrics	Within 30 min to 2 hrs	1–4 wks	As per standards of care
Gynecology	Immediate	2–4 wks	Within 6 mths

*This is only a summary of the WTA's new benchmarks. For complete details, see the WTA website.

Wait Time Alliance

In September 2004, First Ministers agreed to a *10-Year Plan to Strengthen Health Care*. This report card was developed by the Wait Time Alliance (WTA) to provide an assessment of the performance of federal, provincial and territorial governments in meeting their commitments under the 2004 *10-Year Plan to Strengthen Health Care*.

The WTA is comprised of:

- Canadian Anesthesiologists' Society
- Canadian Association of Emergency Physicians
- Canadian Association of Gastroenterology
- Canadian Association of Nuclear Medicine
- Canadian Association of Radiation Oncology
- Canadian Association of Radiologists
- Canadian Cardiovascular Society
- Canadian Medical Association
- Canadian Ophthalmological Society
- Canadian Orthopaedic Association
- Canadian Psychiatric Association
- Canadian Society of Plastic Surgeons
- Society of Obstetricians and Gynaecologists of Canada

Visit the WTA website to access its full range of wait-time benchmarks and reports at www.waittimealliance.ca.

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Wait Time Alliance Report Card

Time for Progress

Benchmarks for achieving meaningful reductions in wait times

April 2008

Wait Time Alliance Report Card

Table 1 Meaningful reductions in wait times (nationally) in the 5 priority areas.

Priority area	Wait time benchmark grade 2007	2008
Diagnostic imaging (DI)		
CT	**TBD**	**TBD**
MRI	**TBD**	**TBD**
Joint replacement (JR)		
Hip	**B**	**B**
Knee	**C**	**C**
Cancer care (Can)		
Radiation oncology	**A**	**A**
Sight restoration (SR)		
Cataract surgery	**B**	**B**
Cardiac care (Car)		
Bypass surgery*	**A**	**A**

Table 1 and Table 2 Letter grading methodology

Wait-time benchmark component (based on provincial websites as of 10 March 2008):
A: 80–100% of population treated within benchmark
B: 70–79% of population treated within benchmark
C: 60–69% of population treated within benchmark
D: 50–59% of population treated within benchmark
F: Less than 50% of population treated within benchmark
TBD: Benchmarks not yet defined by governments
NA: Insufficient data to make determination
NP: Service not provided in province

*Bypass surgery represents only a small part of the full continuum of cardiac care to patients. Please refer to the Canadian Cardiovascular Society website at www.ccs.ca for a full range of benchmarks for cardiovascular services and procedures. All of these benchmarks need to be adopted and performance measured to meaningfully address wait times for cardiac care.

Table 2 Provincial breakdowns: performance and trends in the 5 priority areas.

	Priority areas						
Prov.	**CT**	**MRI**	**Hip**	**Knee**	**Can**	**SR**	**Car***
NL			B	B	A	B	A
PE			A	B	A	F	NP
NS			F	F	NA	B	NA
NB			C	F	A	C	A
QC			A	A	A	NA	NA
ON			A	A	A	A	A
MB			B	D	A	B	A
SK			C	F	D	C	A
AB			A	B	D	A	A
BC			A	B	A	A	A

Table 2 Colour (trend) grading methodology†

This table lists letter grades as well as the change in wait times from 2006 to 2007 for each of the 5 priorities by province as follows:

- ☐ insufficient data to make determination
- ■ significant increase in % of patients treated within the benchmark over the year (5% or higher)
- ■ no significant change in % of patients treated within benchmark (0–4% increase or decrease of 0–9%)
- ■ significant decrease in % of patients treated within benchmark over the year (decrease of 10% or more)

† Based on the following sources: provincial wait-time websites; Canadian Institute for Health Information, *Wait Times Tables — A Comparison by Province, 2008*; *Wait Times Tables — A Comparison by Province, 2007*; Government of PEI; New Brunswick Surgical Care Network; Cancer Care Ontario, Saskatchewan Cancer Agency.

Table 3 Progress toward implementing the 2004 First Ministers' *10-Year Plan to Strengthen Health Care.*

Commitment	Grade 2007	2008
Access indicators	**INC**	**C+**
Establishing wait-time benchmarks	**B**	**B**
Establishing a time table to achieve benchmarks (targets)	**D**	**C+**
Collecting & disseminating wait-time information to the public	**C**	**C+**

Table 3 Grading methodology

Commitments graded based on scale ranging from A (fully met), B (substantially met), C (partially met), D (largely unmet) and F (not met at all). INC refers to incomplete. See technical backgrounder for grading rationale.

Note

It is recognized that there are wide variations in how governments collect and report wait-time data including the wait-time intervals used, the form of measurement used and the timeliness of data. The WTA has attempted to control for these variations to the greatest extent possible. A grade was not assigned in instances where the data were insufficient to make a reasonable assessment.