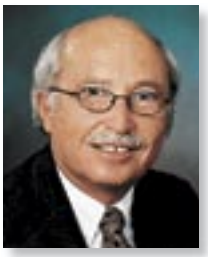

Waiting for wait times

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At the conclusion of the First Ministers' meeting of September 2004, the Prime Minister and premiers promised Canadians that by December 31, 2005, medical wait-time benchmarks would be in place for five priority areas: cardiac care, cancer care, joint replacement, sight restoration, and diagnostic imaging.

On June 9, 2005, the Supreme Court of Canada ruled that a Quebec patient who endured an unreasonably lengthy wait for a hip replacement should have had the right to access privately insured medical care. With this decision, the stakes in the wait-time game skyrocketed and the First Ministers' commitment to define benchmarks to which all Canadians could refer took on added significance.

The past few years have seen the number of activities related to wait times grow across Canada (eg, the Ontario Cardiac Care Network, the Saskatchewan surgical care access program, and the Western Canada Wait List Project). Several research grants to help develop an evidence base for wait-time benchmarks have been awarded by the Canadian Institutes of Health Research. In October 2004, an overwhelming majority of Canadians told a College of Family Physicians of Canada (CFPC)–Decima survey that the wait-time clock starts ticking when patients see their family doctors (if they have family doctors). In March 2005, the Wait Time Alliance (WTA)—a collaborative composed of the Canadian Medical Association and representatives of the medical specialties directly linked to the five priority areas identified by the First Ministers—presented its draft report on wait-time benchmarks.

Since then, the WTA consulted with the other stakeholders before filing its final report on August 10th. The CFPC appreciated meeting with WTA representatives and the attention they paid to our concerns. We support the WTA report as a valuable contribution to the wait-time deliberations but have also recommended to both WTA leaders and government officials that a broader stakeholder team, including family physicians, should now be established to move this process forward. While our Board will further discuss wait-time benchmarks at its December 2005 meeting, the CFPC has presented the following positions throughout the deliberations.

- Wait-time "benchmarks" (goals that reflect medically reasonable wait times) and "targets" (proportion of patients with a given problem who will be treated within the agreed-upon benchmark time limit) should be the same for all Canadians, eg, the wait-time benchmark and target for patients needing hip replacements should be the same from one province to the next.
- Each provincial or territorial jurisdiction should establish its own strategies for meeting these benchmarks and targets, including arranging treatment outside its own boundaries when care is unavailable in a reasonable time closer to home.
- There must be commitments from federal, provincial, and territorial governments that assure patients of access to and payment for the care they need within the benchmarked wait times, regardless of where that care is delivered.
- Wait times should be measured from the time family physicians diagnose problems until definitive investigation or treatment has been carried out.
- Patients should be given a clear explanation of the acceptable wait times defined for their problems; communication of expectation is critical to quality of care. Patients must agree to being placed on wait lists and can ask to have their names removed.
- Patients and their physicians must understand that, to be added to waiting lists that are guided by benchmarked wait times, patients must first meet standardized diagnostic criteria.
- Patients must be assured of high-quality continuing

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Vital Signs

care while they wait. Confirmation of complications or worsening of a condition should lead to accelerated delivery of medical attention.

- Wait-time benchmarks should be developed for medical problems beyond the five priority areas identified by the First Ministers. Two priority areas for which benchmarks should be defined are mental health and emergency care.
- There must be no decrease in or diversion of funding to provide medically necessary services for patients with problems for which there are no wait-time benchmarks.
- Rapid expansion of information systems to record, monitor, and report on patient wait times is essential.
- Shortages of doctors, nurses, pharmacists, and other health care workers must be reversed as a critical part of addressing the crisis facing Canadians concerning wait times and access to care.
- A stakeholder group that includes family physicians and representatives of federal, provincial, and territorial governments should be established to oversee ongoing development, implementation, research, reporting, and accountability related to wait-time benchmarks.
- While the implications of private insurance and payment options should be fully debated by all stakeholders, a prime goal of introducing and achieving wait-time benchmarks should be to strengthen medicare and the single-payer, publicly funded system valued by most Canadians.

Although progress has been made in defining wait-time benchmarks for Canada, much still remains to be done. Once wait-time benchmarks are announced by the First Ministers, it is doubtful that the public—or the courts—will tolerate much delay before they expect the system to deliver on its promises. The moment is drawing nearer when the June 9th Supreme Court decision and its implications for a private-public system in Quebec will become the precedent for all jurisdictions. We hope that our elected leaders understand this and are prepared for the consequences should they be unable to ensure provision of publicly funded services within medically acceptable wait times for all Canadians.