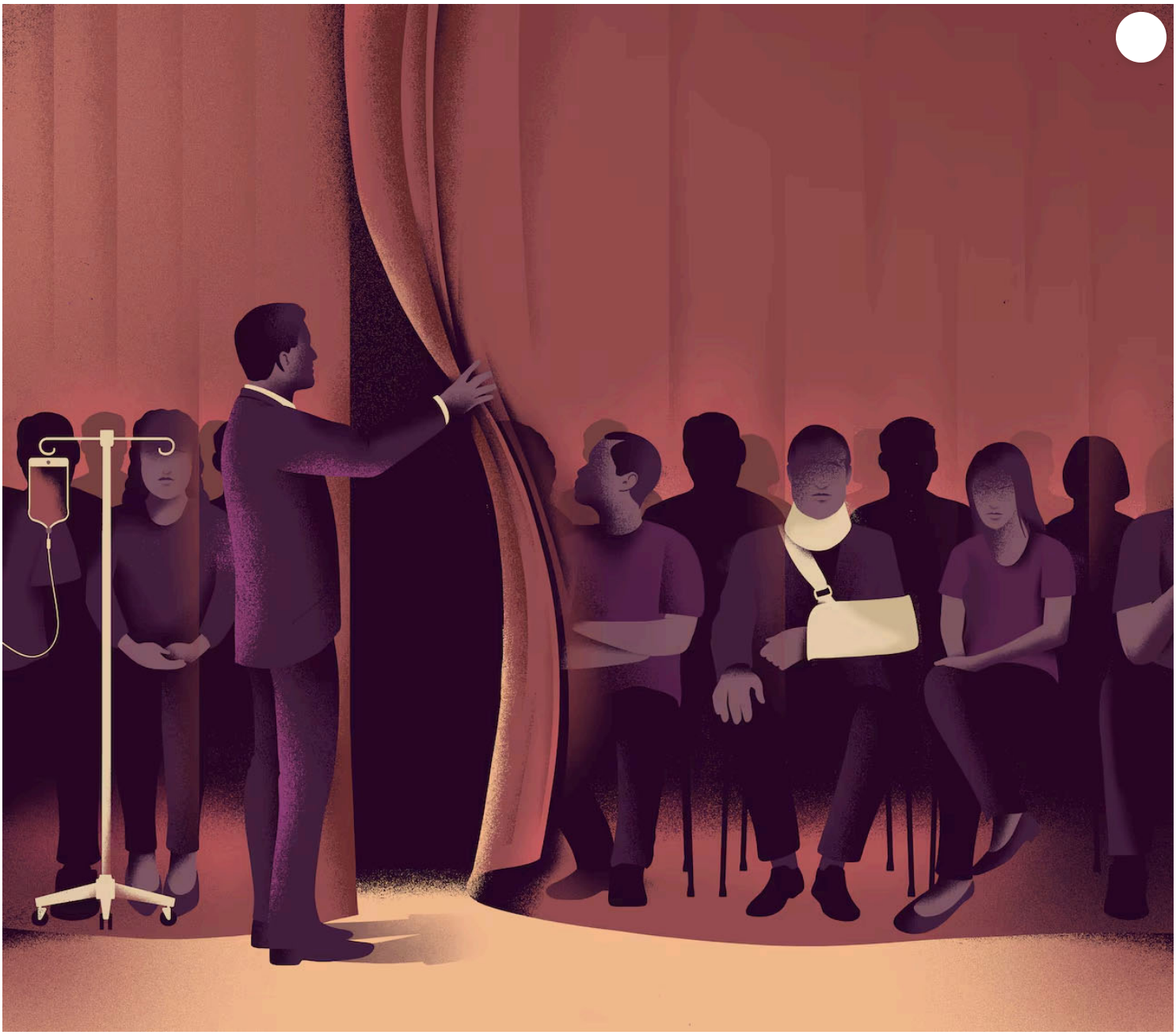


SECRET CANADA

# Scan inconclusive: The rough state of emergency care

In many provinces' hospitals, wait times stubbornly refuse to come down to prepandemic levels – and others gave out no data about how they're faring, a Globe analysis finds

TU THANH HA AND YANG SUN
DATA ANALYSIS AND GRAPHICS BY YANG SUN AND MURAT YÜKSELIR
THE GLOBE AND MAIL

PUBLISHED OCTOBER 4, 2024

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ILLUSTRATIONS BY SÉBASTIEN THIBAULT

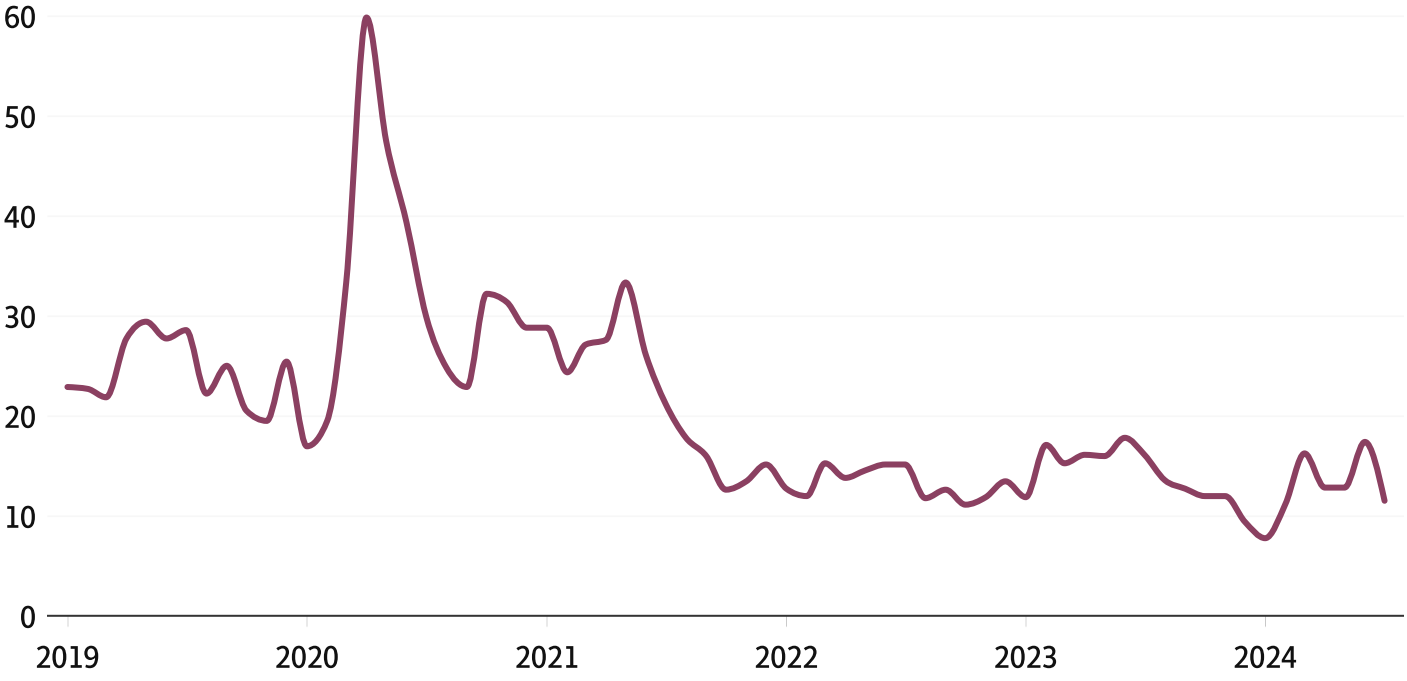
Nearly five years after COVID-19 first struck, emergency departments across the country remain bogged down by lengthy waiting times.

At the Montreal General Hospital, emergency patients who aren't able to walk by themselves can expect to spend, on average, a whole day on stretchers, 10 more hours than at the start of the pandemic.

At the Saskatoon City Hospital, people who needed to be admitted from the emergency room to an in-patient bed typically had to wait more than two days last winter.

**Percentage of Ontario hospitals that met the 8-hour maximum-stay target in emergency for admitted patients**

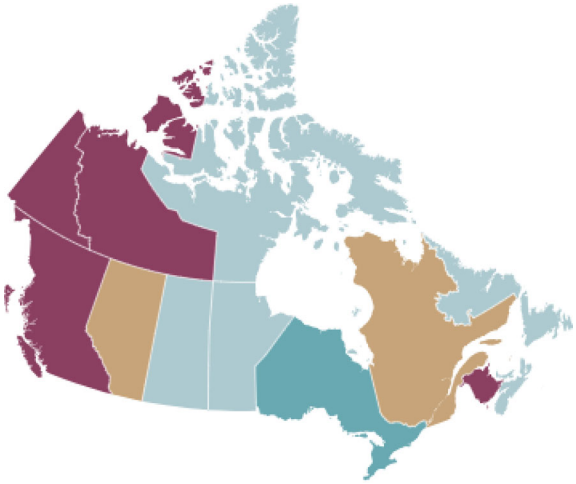
From January 2019 to July 2024




THE GLOBE AND MAIL, SOURCE: ONTARIO HEALTH

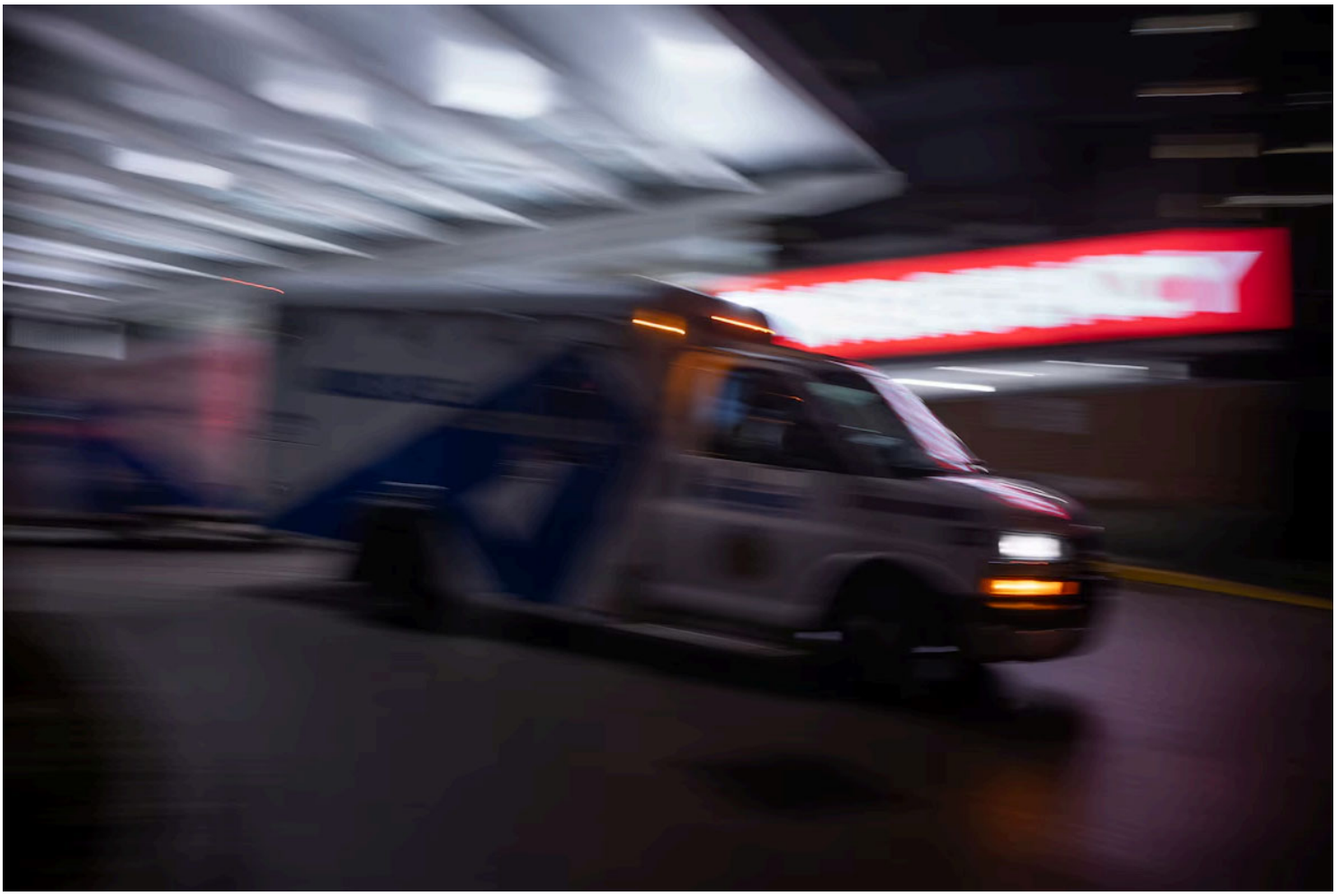
## How health authorities responded to The Globe's data request

Received data through Freedom of Information request  Received data through media request  No data was received from request, but downloaded data from online dashboard  No data received



THE GLOBE AND MAIL





At Ontario hospitals such as Toronto Western, emergency patients with serious conditions are not meant to wait more than eight hours, but fewer ERs can meet that target.

IAN WILLMS/THE GLOBE AND MAIL




When services resumed during the pandemic, staff shortages and more complex patient problems made wait times worse, Toronto ER physician Clare Atzema says. 'I used to be able to look after one person having chest pain. Now they have kidney failure on top of a cancer in the background.'

JENNIFER ROBERTS/THE GLOBE AND MAIL



Michael Howlett, ex-president of the the Canadian Association of Emergency Physicians, sees statistics as crucial – 'it affects how many people die, it affects how many people suffer needlessly' – and has long fought for better access and data sharing between hospitals.

IAN WILLMS/THE GLOBE AND MAIL

At the start of this year, only one in 10 Ontario hospitals met the provincial target waiting time for patients with serious conditions, compared with 25 per cent before the pandemic.

Those numbers were gathered by The Globe and Mail as part of the Secret Canada: Your Health project, which confirms the anecdotal experiences of patients who have sought care in the aftermath of the pandemic – emergency departments are still struggling to serve their many users.

But the project also spotlights something that patients are less likely to feel directly – the black holes in data collection that persist across the country about this fundamental health care service. Some provinces, such as New Brunswick and Newfoundland and Labrador, were unable to provide detailed ED metrics to The

Globe, and they also don't participate in the only pan-Canadian effort to grasp this basic performance indicator, assembled by the Canadian Institute for Health Information, known as CIHI.

"As we pour tens and maybe hundreds of billions of dollars into health care, we should know what we're paying for. And also, the missing piece here is what do the patients get?" said Jason Sutherland, interim director of the Centre for Health Services at the University of British Columbia's Faculty of Medicine, School of Population and Public Health.

The Globe set out to collect waiting times for every hospital emergency department, for every month since 2019. We contacted every health administration, first from provincial and territorial ministries, then, if redirected, from regional health authorities. We also filed 13 freedom of information requests. Although four provinces and one territory provided the requested detailed data, other jurisdictions said they didn't track waiting times or didn't have detailed breakdowns. Others were unable to respond within the two months we carried out this research – or in some cases, simply stopped responding to The Globe's inquiries.

We took these steps because, although Canada has a clearing house for health care statistics, some provinces don't contribute at all, and others only partly, to CIHI's large data set on emergency care. Furthermore, CIHI doesn't routinely release monthly ED metrics for all hospitals. The institute said handling The Globe's request would be a lengthy process costing $180 per hour.

In a digital age when anything can be measured, it remains a challenge for regular users of the system to gather data to compare how various hospital emergency departments are performing. Doctors, academics and other experts say that there is a need for better metrics about EDs, for the sake of accountability and transparency. "If you're not measuring that, how do you know if you're doing well, compared with what are acceptable standards?" said Michael Howlett, an emergency physician in the Toronto area.

Three decades ago, Ottawa, the provinces and the territories created CIHI, an independent not-for-profit organization to collect health indicators across the

country – an entity that was, in theory, supposed to bridge Canada's archipelago of 13 provincial and territorial health care systems.

One of CIHI's largest data sets is the National Ambulatory Care Reporting System, which holds 20 million records, most of it about emergency departments. NACRS was created in 2002 and holds information for over 85 per cent of emergency department visits in Canada. Experts say it provides a good overall portrait of the Canadian emergency care experience – one researcher, Clare Atzema, points out there are "only a couple of other countries in the world where you can get this kind of data" – but its scope and complexity mean that not all hospitals have the resources to contribute data.

The process of extracting medical information and compiling it into a standardized format for CIHI is called abstracting. It requires specialized software and CIHI-trained "abstracters."

"It's a critical starting point. But it costs money, of course, that each hospital has to pay someone … to go through every chart," said Dr. Atzema, a senior scientist in Toronto for the Institute for Clinical Evaluative Sciences.

As a result, New Brunswick, Newfoundland and Labrador, the Northwest Territories and Nunavut are missing from NACRS and there is only partial coverage for Prince Edward Island, Nova Scotia, Manitoba, Saskatchewan and British Columbia.

"Data is the bane of the health services researcher," said Dr. Sutherland, who noted that, as a Vancouver-based researcher, he has to deal with the fact that not all hospitals in his province report to NACRS. He noted that B.C. is also absent from some other CIHI databases "I spend half of my time fighting to get access to data." For his province's health indicators, Dr. Sutherland often has to turn to a multi-university resource, Population Data BC. However, only authorized academic researchers have access to that data.



At the University of British Columbia, researcher Jason Sutherland often finds himself fighting for information about B.C. hospitals that don't all report to the same database.

JENNIFER GAUTHIER/THE GLOBE AND MAIL

NACRS tracks the indicators The Globe wanted to access – including the time elapsed between triage and initial assessment, as well as intervals for patients who required admission to a hospital bed.

However, the data tables that CIHI releases for these metrics on its website provide only provincial breakdowns.

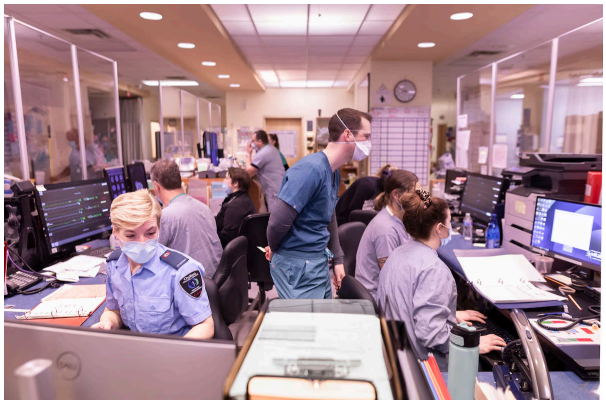
CIHI pointed us to its interactive user-oriented online portal, called Your Health System, which enables users to find key health indicators for either their province, region, city or hospital – and compare those numbers to other locations.

However, NACRS's incomplete coverage of the entire country becomes apparent when using this online tool.

On the portal, there are no waiting-times data for Newfoundland and Labrador – a province that has acutely suffered from staffing shortages and backlogs in its emergency rooms.

Last year, The Canadian Press reported that deaths in the province's emergency departments rose to 326 people, up from 262 in each of the previous two years.

It is the same issue for New Brunswick, another province that supplies no data to NACRS.



Moncton's Georges Dumont University Hospital is the nerve centre of Vitalité Health Network, whose pandemic staffing losses made them consider deep cuts to ER capacity.

SUPPLIED/DANIEL ST. LOUIS

Like other Canadian jurisdictions, New Brunswick lost health care employees because of the pandemic and its two regional health authorities increasingly had to rely on for-profit companies to supply temporary workers. France Desrosiers, the CEO of one of the two authorities, Vitalité Health Network, has said the staffing attrition made her consider closing the emergency department at the Campbellton Regional Hospital and reducing the emergency capacity at Georges Dumont University Hospital by 65 per cent.

Since there is no NACRS information for New Brunswick, The Globe asked Vitalité for ED indicators starting back in 2019. The health network replied that "we are unable to provide reliable data on wait times at emergency departments."

However, New Brunswick's Health Department said in an statement to The Globe that it is "working with the regional health authorities on ensuring emergency department wait time data is consistently and accurately collected from facilities across the province."

The department didn't answer a question about New Brunswick not contributing to NACRS.

When asked about the absence of New Brunswick and Newfoundland from its emergency care statistics, CIHI said in a statement that it is up to provinces to

determine whether they wish to submit information. “CIHI, as an independent, non-for-profit organization, does not and cannot compel provinces and territories to share data.”

Some hospitals in Nova Scotia are also missing from the Your Health portal. That includes Cumberland Regional Health Care Centre in Amherst, where Allison Holthoff, 37, died on the last day of 2022. A single emergency physician was on duty during the seven hours she waited before her death from complications from a splenic artery aneurysm, according to court documents in a lawsuit filed by her family.

Cumberland Regional sends its day surgery data to NACRS but not emergency metrics. “Hospitals not yet submitting their ED visit information to NACRS typically have constraints related to availability of digitized data,” CIHI said in a statement.

The Globe asked the province for detailed data, with a hospital breakdown, but Nova Scotia Health could only provide aggregated figures for regional health authorities.

Even for provinces that fully contribute to NACRS, there can be complications when checking CIHI’s portal.

In several cases, especially in Ontario, there is data for a hospital network, but not for its individual hospitals, making it impossible to compare waiting times between the largest hospitals in major cities. Similarly, for Quebec, often there are no entries for specific hospitals but instead data for their regional health authorities.

NACRS holds data for specific facilities but the Your Health System portal doesn’t make them publicly available because other indicators included in it, for example acute care, are managed at the hospital network level, CIHI said.



Allison Holthoff, with husband Gunter in a family photo, died in late 2022 at a hospital in Amherst, N.S., in circumstances that led the family to sue.

SUPPLIED BY GUNTER HOLTHOFF VIA CP

Another type of data that has become accessible for the public are real-time dashboards that tell patients how long they can expect to wait if they show up at their local hospital.

However, Alan Drummond, a veteran emergency physician at the Perth and Smiths Falls District Hospital, cautions about these dashboard tools because they cannot forecast with certainty the severity of the patients' inflow. "What is true one minute may not be true the next, when a cardiac arrest or trauma code are wheeled in through the back door," he said.



At Toronto's Mount Sinai hospital, average waiting times have been above the provincial average since early 2022, according to the data collected by The Globe. Last October, patients would wait 30.8 hours on average in emergency, though that improved in the succeeding months.

IAN WILLMS/THE GLOBE AND MAIL

The Globe tried to go straight to the provinces and regional health authorities that store the answers about how their emergency departments are performing. But there

is no quick way to line up numbers from St. John's to Victoria.

We asked for the average length of stay, average waiting time for triage, average waiting time for first doctor assessment, and average waiting time for a bed. We sought a breakdown by month and hospital for every province and territory.

Although some jurisdictions were able to provide numbers directly, others said a Freedom of Information (FOI) request would have to be filed. FOI applications are not a rapid process. Depending on the province, public bodies have 30 to 45 days to respond, but in practice it can take longer to receive the information. In some cases, the communication takes place via fax or postal mail and payments are done by cheque.

The most detailed, complete information came from Ontario Health, the agency that manages the province's health care delivery, for a $720 fee.

Saskatchewan provided data by sending 33 pages of tables in printout format – meaning the waiting times could not be sorted, analyzed or charted until The Globe converted those numbers into a computerized spreadsheet.

Alberta told us to consult an online dashboard that has waiting times for only a portion of its hospitals. Downloading data from that panel required us to pore through the web page's code.

British Columbia was first contacted at the end of July. In late September, its health department said it would not proceed with our request because a provincial election had been called so "we can reconnect next month."

## A snapshot of data received by The Globe

The Globe requested the data to be broken down by hospital and month, as well as cover the following four indicators:

- Average length of stay in the ED for all patients;
- Average length of stay in the ED for discharged patients;
- Average length of stay in the ED for admitted patients;
- Average waiting time for first doctor assessment.

However, not all authorities met the requirement.

| PROVINCE/ TERRITORY | HEALTH AUTHORITY | AGGREGATE LEVEL | DATA SINCE 2019? | DATA FREQUENCY | HAVE COMPLETE COVERAGE OF EDS IN THE JURISDICTION? | INCLUDE ALL INDICATORS? |
|---|---|---|---|---|---|---|
| Alberta | Alberta Health Services | Hospital | Yes | Month | No | No |
| Manitoba | Shared Health | Hospital | Yes | Month | Yes | Yes |
| Manitoba | Southern Health | Hospital | Yes | Month | No | Yes |
| Manitoba | Interlake-Eastern Regional Health Authority | Hospital | Yes | Month | No | Yes |
| Manitoba | Northern Regional Health Authority | Hospital | Yes | Month | No | Yes |
| Manitoba | Prairie Mountain Health | Hospital | Yes | Month | No | Yes |
| Newfoundland and Labrador | NL Health Services | Health zone | Yes | Quarter | Not applicable | Yes |
| Nova Scotia | Nova Scotia Health | Health zone | Yes | Month | Not applicable | Yes |
| Nova Scotia | IWK Health Centre | Hospital | Yes | Month | Yes | Yes |
| Nunavut | Department of Health | Hospital | Yes | Year | Yes | No |
| Ontario | Ontario Health | Hospital | Yes | Month | Yes | Yes |
| PEI | Health PEI | Hospital | Yes | Month | Yes | Yes |
| Quebec | Quebec Health | Hospital | No | Year | Yes | Yes |

| | Department | | | | | | |
|---|---|---|---|---|---|---|---|
| Saskatchewan | Saskatchewan Health Authority | Hospital | Yes | Month | No | | Yes |

THE GLOBE AND MAIL

The data collected so far by The Globe reflect the roller coaster of turmoil caused by COVID-19.

First, there was a brief interlude where waiting times improved because there were lockdowns and people avoided hospitals. “We were sort of teetering on the edge and then COVID-19 hit and initially, it was tumbleweeds going through the ER, because nobody came,” recalled Dr. Atzema, who is an emergency physician at Toronto’s Sunnybrook Health Sciences Centre.

When medical services resumed, waiting times got worse because of staff shortages and because patients were in worse shape.

The data show that Sunnybrook had some of the lengthiest waiting times for admitted emergency patients in Toronto, with an average of 25.9 hours in July. The hospital said that, as Canada’s largest trauma centre, it has to give priority to some of the most critical cases.

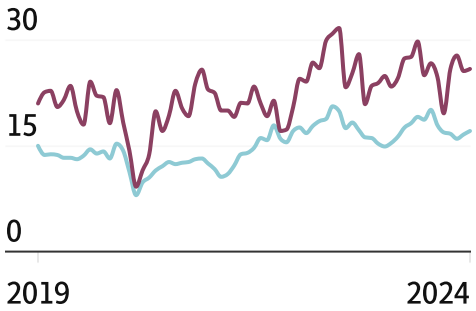
Conversely, another Toronto hospital, Humber River Health, had the shortest time for admitted cases, at less than 10 hours. Humber River credited its use of a control centre that uses real time data to analyze the flow of patients and detect when urgent measures are required.

## Average length of stay in emergency for admitted patients at Toronto hospitals

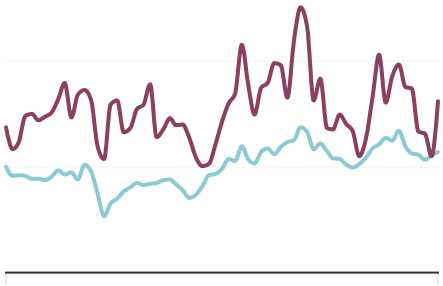
In hours. January 2019 to July 2024

Ontario average — Monthly average of the hospital

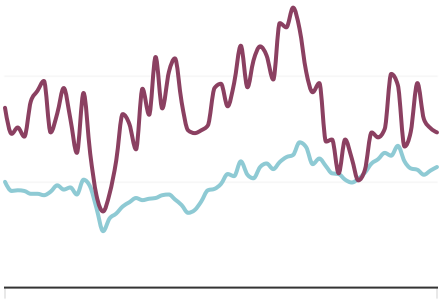
### Sunnybrook Health Sciences Centre



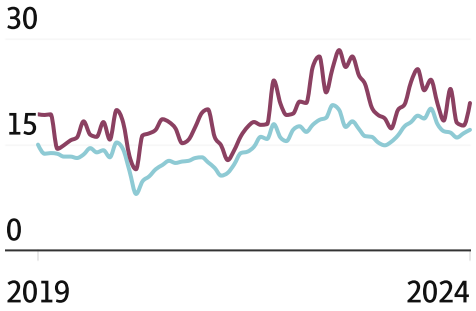

### William Osler Health System - Etobicoke Site



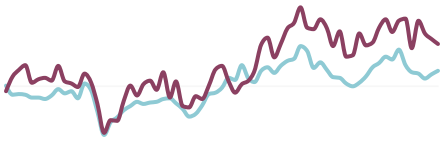
### Unity Health Toronto - St. Joseph's



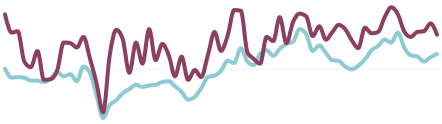
### University Health Network - Western Site



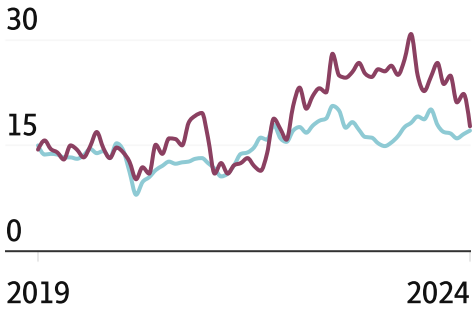

### University Health Network - General Site



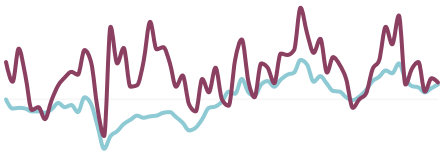
### Scarborough Health Network - Centenary Site



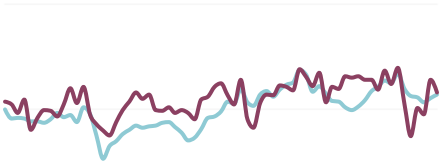
### Sinai Health System – Mount Sinai Hospital Site



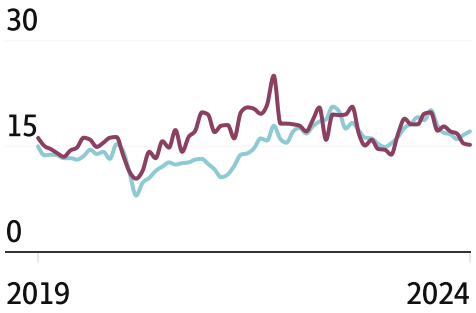

### Scarborough Health Network - General Site



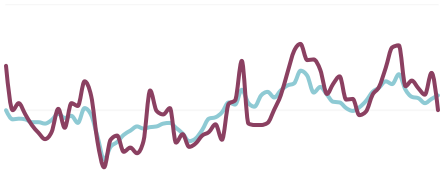
### Unity Health Toronto - St. Michael's



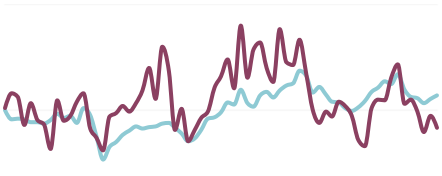
### Toronto East Health Network - Michael Garron Hospital

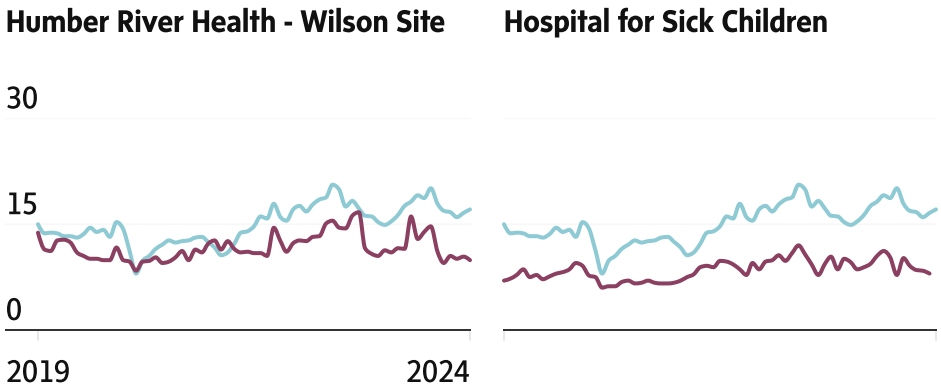



### Scarborough Health Network - Birchmount Site



### North York General Hospital

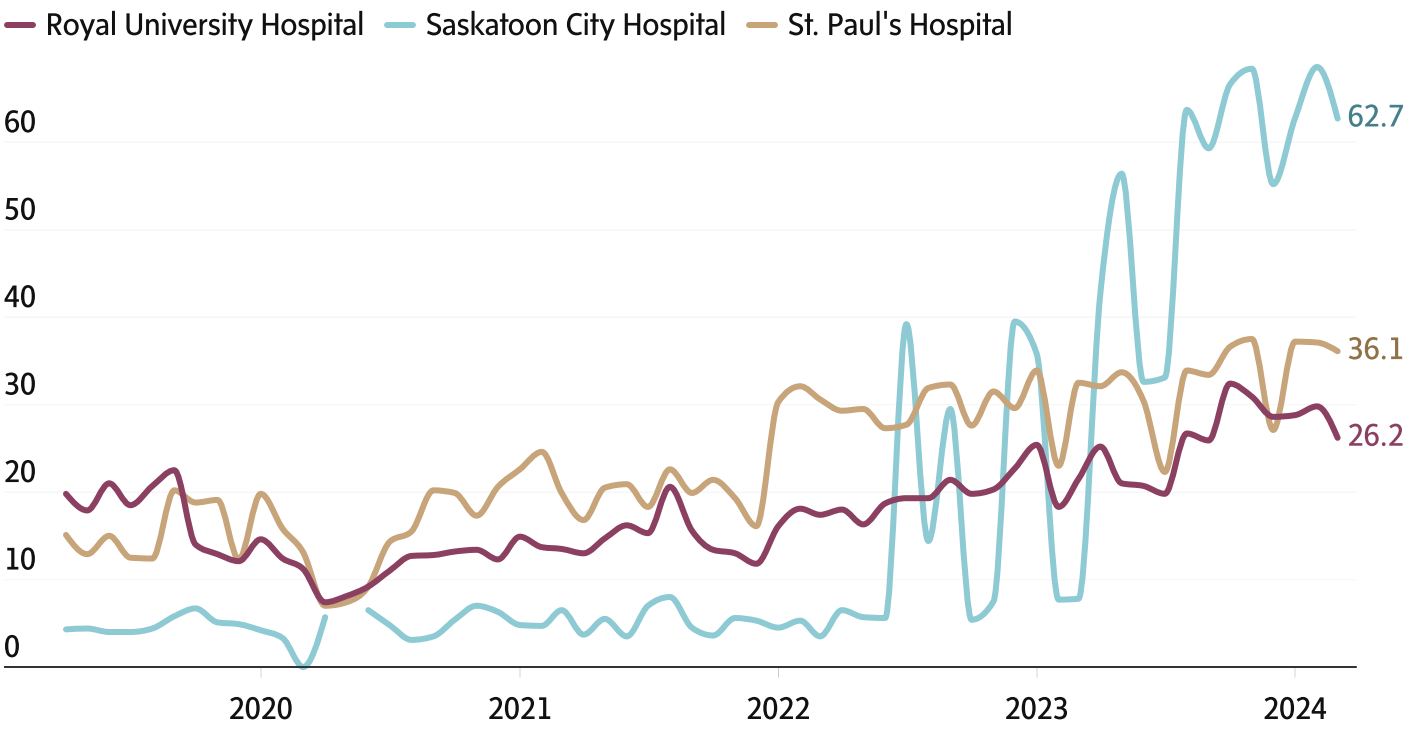





THE GLOBE AND MAIL, SOURCE: ONTARIO HEALTH

In Saskatchewan, the Saskatoon City Hospital made the news last January after it had to restrict emergency services one evening because some of the doctors were ill. The disruption occurred midway through an eight-month stretch when the hospital's waiting times had soared. The average length of stay for emergency patients waiting for a bed jumped from 33 to 64 hours between July and August of 2023. In the following seven months, that indicator remained stuck between 55 and 68 hours.

**Average length of stay in emergency for admitted patients at Saskatoon hospitals**
In hours, from April 2019 to March 2024




THE GLOBE AND MAIL, SOURCE: SASKATCHEWAN HEALTH AUTHORITY

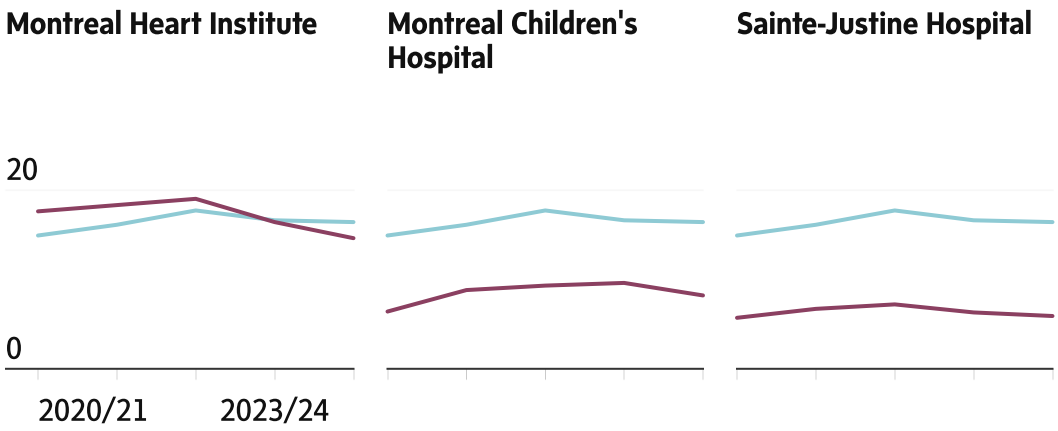
Emergency waiting times also soared in Quebec. At the Montreal General Hospital, patients went from having to spend 15 hours on average on hallway gurneys in 2020 to over 24 hours this year. Spokeswoman Annie-Claire Fournier said the Montreal

General serves an older population. “It is these patients waiting for hospitalization that are driving up our lengths of stay in the ER,” she said, adding that elderly patients take up beds while they wait to be transferred to rehabilitation, long-term care or home care.

## Average length of stay in emergency for patients on stretchers at Montreal hospitals

In hours, by fiscal year






THE GLOBE AND MAIL, SOURCE: QUEBEC HEALTH DEPARTMENT

The main problem, emergency physicians say, is the chronic dearth of hospital beds, which forces emergency patients to be "boarded" – to be kept waiting in a hallway stretcher. Alternate level of care (ALC) patients, who no longer need hospital care but can't be discharged because there are no nursing home spots for them, are a significant cause for such bottlenecks.

"The maddening thing about prolonged waits for emergency care is that we know, basically, that the principal driver is insufficient bed capacity in hospitals leading to prolonged boarding in the ER," Dr. Drummond said.

"Governments know that too and yet the response, consistently, has been to blame and shame the public for overusing the ER for minor non-urgent complaints."

Using data to document and study the impact of such delays is crucial, Dr. Howlett said. "It affects how many people die, it affects how many people suffer needlessly. All you have to do is watch people in the hallways like I did an hour ago, lying in the hallways for hours and hours or days."

Dr. Howlett is the former president of the Canadian Association of Emergency Physicians, which has long called for better ED statistics.

Health care indicators were big news in 2004 when prime minister Paul Martin tied an $18-billion funding package to provinces having to meet waiting-time benchmarks in areas such as joint replacements and cataract procedures. Surgical waiting times have become a common part of the public debate on health care and are mentioned in media reports, research papers and major court cases about timely access to medical services.

The same requirement came up last year when Prime Minister Justin Trudeau announced $46.2-billion in new health care spending. To get money in four priority areas – primary care, health care work force, mental health and addiction, and digital medical records – provinces and territories agreed in bilateral deals to track their performance via a new set of benchmarks being developed by CIHI.



Emergency services were not included among those indicators even though easing ED congestion was an underlying concern in several of the bilateral deals. The New Brunswick agreement for example will fund nurse practitioners "as an alternative to emergency department visits." The Prince Edward Island bilateral deal mentions primary care and mental health care initiatives "easing pressure on emergency departments."



An $18-billion health deal from 2004, hashed out by Paul Martin and premiers in Ottawa, set out 'evidence-based benchmarks' for waiting times that made data critical to success.

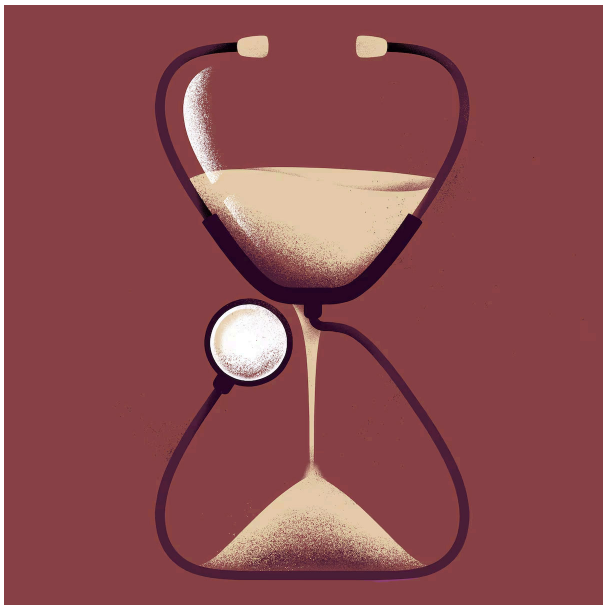
FRED CHARTRAND AND TOM HANSON/THE CANADIAN PRESS

The Canadian Medical Association argued in an analysis prepared by the consulting firm Deloitte that the deals required more scrutiny. The report noted for example that no one is formally tracking the closings of emergency departments and that NACRS doesn't cover all provinces.

One of the co-authors, Deloitte economist Matthew Stewart, said in an interview that a recurring difficulty he faces in analyzing health policies is either having only partial indicators, or indicators that are mismatched or indicators that are hard to obtain. "I've done a lot of health projects. Getting the data is always the challenge."

Health Canada did not respond to a Globe query about the absence of ED indicators in the bilateral agreements.

In interviews with The Globe, emergency physicians who advocate for their association remarked on how difficult it was to get some provinces to contribute to the CIHI data set – and how unfortunately that is still the case today.



Two decades ago, Dr. Howlett and Andrew Affleck, who was at the time the president of Canadian Association of Emergency Physicians, were in Fredericton to urge the New Brunswick government to contribute to NACRS.

They had asked to meet the province's health minister or deputy minister, but were redirected to lower-ranked bureaucrats. Dr. Affleck recalled that he explained how collecting data would help identify bottlenecks in emergency services. "There was really no commitment afterwards to look at anything."

*With additional reporting by Fatima Raza*

## State of health: More from The Globe and Mail

**Toronto hospital system offers housing to homeless ER patients**

**For First Nations, diabetes takes a harsh, often preventable toll**

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*Alika Lafontaine, the first Indigenous president of the Canadian Medical Association, unpacks that institution's recent apology to First Nations, Inuit and Métis people for decades of racist policies that did them harm.*

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