Ensuring equitable access to high-quality, cardiovascular care

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Société canadienne de cardiologie
Communauté. Connaissances. Leadership.

Recommendation: That the federal government partner with the Canadian Cardiovascular Society to define wait time targets for priority conditions beginning with screening, diagnosis, and management of heart failure.

Background

Heart disease is a leading cause of death and disability among Canadians,[1] and premature death for women.[2] About 2.4 million Canadian adults aged 20 years and older are living with ischemic heart disease, and another 750,000 Canadian adults aged 40 years and older are living with heart failure – a chronic, progressive condition that requires ongoing management.[3, 4, 5] Heart disease occurs when the heart is not able to properly circulate blood throughout the body following heart damage or because of a weak heart. Regardless of the initial cause, many cardiovascular conditions lead to heart failure, and it remains one of the top 3 reasons for hospital admission in Canada.[4, 6]

The economic burden is also significant, costing the Canadian economy more than $21.2 billion annually, including more than $2.8 billion (or 1% of GDP) related to heart failure.[7, 8, 9] The COVID-19 pandemic has measurably increased these costs as waitlists for non-elective cardiac procedures have grown, and patients awaiting postponed procedures have become more gravely ill.

Tracking healthcare system performance through a comprehensive set of metrics and using targets to guide investments and decision-making are critical to high-performing healthcare systems. This is essential to ensure equitable access to care – a shared value across the country. It is especially important for Canada's most vulnerable populations – those who are geographically, racially, and/or socially marginalized – who have higher rates of heart disease and experience worse outcomes.[10] Therefore, we recommend:

That the federal government partner with the Canadian Cardiovascular Society to define wait time targets for priority conditions, beginning with screening, diagnosis, and management of heart failure.

The need

Primary care providers – namely family doctors and nurse practitioners and selected services from pharmacists – serve a critical role in screening, detection, and ongoing management of cardiovascular disease. Yet 6.5 million Canadians do not have a family physician or nurse practitioner they see regularly.[11]

The Canadian Cardiovascular Society (CCS) supports ongoing efforts to improve supply and access to primary care through a variety of means including facilitating physician mobility across provinces/territories, increasing training opportunities, and accelerating credentials for internationally trained health care providers.

When timely access to primary care is not met, Canadians living with cardiovascular disease often end up in the emergency room after their clinical condition has deteriorated and where care is much more expensive. This is a common outcome for Canadians living with heart failure. Many Canadians end up in the hospital, where they remain longer than necessary as they wait for home care, inadvertently blocking the admission of additional patients. In other instances, people living with heart failure face barriers in accessing medications, which may be too costly. As a result, their condition often worsens, and they end up with repeated visits to primary care or unplanned hospital readmissions. The interconnectedness of all the sectors in health care has been underappreciated, and poor communication and siloed funding has inhibited real integration that could improve care. There are insufficient health care providers, many of whom cannot practice to their full scope; there is limited operating room time; there are limited machines for advanced imaging; and there are significant other shortages of human and material resources that contribute to growing wait lists. Wait times for specialist care and diagnostic imaging, in turn, increases the burden placed on family doctors. Patient visits to family doctors increases when patients are unable to readily access specialist care, and their health conditions deteriorate during preventable delays in specialist care. There is an enormous administrative burden on health providers and decreased time for patient care. In order to implementi solutions that will reduce wait times, specific intervention points must be known, and targets must be identified at the outset to determine if the changes have been successful. The Government of Canada has not embraced the notion that we need to measure and publicly report wait times beyond the few procedures identified over two decades ago.

At that time, Canada's First Ministers agreed to focus on wait time reductions across five areas of care including coronary artery bypass and diagnostic imaging. This effort involved

collaboration between provincial governments and the Canadian Institute for Health Information (CIHI) to improve public wait time reporting. While wait time reductions took place, health systems and cardiovascular care have evolved significantly since that time and the standards have not been updated since 2015. Furthermore, things are not better in disease areas outside of those defined benchmarks.

The bilateral commitments between the federal, provincial, and territorial governments in Budget 2024 included the identification and measurement of targets and annual reporting. Establishing updated wait time benchmarks is an important metric that the federal government can use to ensure funding is used appropriately and improvements in care are meaningful. The CCS is well-positioned to lead this initiative beginning with heart failure. The CCS will also facilitate critical buy-in from health care providers, governments, and patients.

Policy makers have learned about the causes of high wait times and the variety of strategies that can be employed to address them. However, most of these efforts have focused on hospital care to improve patient flow and to centralize the intake of surgical patients. While this has resulted in improvements, it represents one part of the system and does not address the range of contributing problems. In addition, quality improvement efforts by health care providers to prevent, screen for and treat illnesses are implemented daily. However, these efforts cannot be effective within a system not designed to support the modern health care needs of Canadians.

Notably, some provinces have reported on wait times for some areas of care, but there are no national benchmarks and no accountability to achieving acceptable wait times in Canada. For example, the province of Saskatchewan has focused on reducing wait times by defining targets, adding resources, introducing innovative practices and tools, and enabling care providers to provide care within their full scope of practice. While this is making a difference, Canadians across the country can and should expect more. Health care delivery in Canada lags behind that of Netherlands, Germany, Switzerland, and Australia, in part because we lack a consistent and holistic, coast-to-coast-to-coast strategy to identify systemic issues and implement targeted improvements. This must change and a commitment to significantly reduce wait times for life-saving medications was included in the 2025 Liberal Party election platform. A critical part of addressing issues with access, including access to medications, includes publicly reporting on a range of metrics that reflect performance among provincial,

territorial, and federal health systems. These findings will reveal where change has been effective and where gaps in care remain.

Our plan

The CCS is the right partner for the federal government to build consensus and establish updated wait time benchmarks that will guide health system improvements. Starting with heart failure, the CCS will:

1. Create and convene an expert task force who will be responsible for establishing evidence-based heart failure wait times for Canada. Wait times will include all aspects of care such as diagnostic testing, access to specialists, multi-disciplinary programs, and newer areas of specialties/procedures such as Transcatheter Aortic Valve Implantation (TAVI).
2. Identify key partners (e.g., heart failure care providers, people with lived experience, provincial/territorial governments, non-governmental organizations, vulnerable populations) who will be consulted to develop heart failure wait time benchmarks.
3. Assess current heart failure wait time data sources and make recommendations for enhanced data and reporting.
4. Seek input about heart failure-related wait times and additional data required from key government officials.
5. Identify challenges and priority areas of improvement.
6. Publicly report heart failure wait time benchmarks.
7. Evaluate the process and consider expanding to other areas of cardiovascular care and chronic disease.

The estimated budget to establish heart failure wait times is as follows:

Year	**Budget**
2026	$ 750,000
2027	$ 1 250,000
2028	$ 1 000,000

TOTAL	**$3 000,000**

To be successful, the CCS will consult people with lived experience, care givers, and family members to ensure meaningful health system change. This means taking a patient-centred approach to this work, including involving patients in program planning, implementation, evaluation, and policy development.

First Nations, Métis and Inuit communities must also be involved given the current state of Indigenous Peoples' health in Canada is a direct result of previous government policies, and the federal government must work in consultation with Indigenous Peoples to close the gaps in health outcomes between Indigenous and non-Indigenous communities[12]. . We pledge to work with Indigenous Peoples to define a path for equitable access to care that is described and led by Indigenous Peoples.

Priority populations include children and youth (<18 years), older adults (≥65 years), and individuals experiencing social or structural disadvantage. Despite common assumptions, there are pediatric patients living with cardiovascular disease. These are young patients who often receive excellent life-saving acute care but are lost in the transition from child to adult care. They wait for referrals to specialists and multi-disciplinary programs and wait times are currently unacceptable.

Conclusion

Heart failure and other cardiovascular conditions continue to impose a significant burden on Canadians and our healthcare systems. Inconsistent access to timely, high-quality care leads to poorer outcomes and higher healthcare costs, especially among our most vulnerable populations. The CCS and the federal government have an opportunity to work together to establish national, evidence-based benchmarks and catalyze health system improvements. Additionally, as a significant provider of healthcare funds to the provinces and territories, the federal government has an interest in establishing accountability for the health services provided by the provinces and territories and by its own programs. We need leadership from our federal government to help define current national benchmarks, beginning with heart failure. The CCS is a credible and respected leader in health care who is well positioned to ensure that an evidence-based process is implemented to define benchmarks in care. This will

ultimately help to improve the quality, equity, and efficiency of cardiovascular care for Canadians.

About Us

The Canadian Cardiovascular Society (CCS) is the national, non-profit professional organization that represents more than 2,500 cardiologists, cardiac surgeons, and scientists across Canada. Established in 1947, the CCS supports heart care specialists by setting national standards, sharing knowledge, and informing policy. For more information, visit www.ccs.ca.

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