CFMS National Day of Action (NDoA) Emergency Department Wait Times: Improving Access to Emergency Care

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Introduction

Canadian healthcare prides itself in being a universally accessible and publicly funded system, meaning that any Canadian citizen or permanent resident can obtain public health insurance and receive care for most health services without charge [1]. However, universal access is not the sole contributor to an effective healthcare system that meets its population's needs. Timeliness of care is also essential, and longer emergency department (ED) wait times are compromising the system's overall efficacy.

The Canadian healthcare system has multiple levels of care. Notably, primary and emergency care are two that are central to patient access and outcomes. Primary care focuses on preventative care and managing chronic conditions, with the possibility to connect patients to specialized services as needed. It is often the first point of contact for individuals seeking healthcare and thus the foundation of healthcare systems. In contrast, emergency care deals with acute or life-threatening medical issues that require immediate attention. Although distinct, these two levels of care are intrinsically linked. If primary care fails or is unable to meet the demands of its patient population, emergency care also suffers.

Across Canada, EDs are increasingly becoming a default setting for primary care, especially for individuals who do not have a family doctor or who cannot access health-related services in their communities. This trend is often worse in rural areas, where shortages of primary care providers force patients to turn to their local ED [2]. Increased ED demands combined with staff shortages has forced many rural EDs to temporarily or permanently close [3]. Another major factor in lengthening ED wait times is Canada's aging population, who seek care more often and have more complex needs than younger adults. As more Canadians seek care in the ED for non-urgent issues (e.g., chronic disease management), the system becomes further strained, leading to longer wait times and delayed access to care.

While health care is mainly the responsibility of provinces and territories, the federal government, which helps provide funding and sets national standards, has a clear stake in addressing rising ED wait times because of its significant impact on the sustainability and effectiveness of our health care system.

Current Landscape

In 2024-2025, the average Canadian ED wait time to see a doctor (i.e., time from triage to physician initial assessment) was **1 hour 53 minutes** [4,5]. It is important to note that wait times vary with acuity level; more acute cases receive care sooner. When arriving in an ED, patients are first assessed by a triage nurse and assigned a score based on the Canadian Triage and Acuity Scale (CTAS) from Level 1 (resuscitation) to Level 5 (non-urgent). Patients are then prioritized

based on their score, with CTAS guidelines recommending Level 1 patients to be seen immediately by a physician 98% of the time and Level 5 patients to be seen within two hours by a physician 80% of the time [6]. Additionally, the underlying causes of prolonged ED wait times usually differ between urban and rural settings. In rural areas, staff shortages are a key issue and have led to temporary ED closures in some communities. In urban areas, high patient volumes and limited inpatient bed availability contribute significantly to delays [7].

After treatment in the ED, patients will either be sent home ("discharged") or "admitted" to an inpatient bed in a hospital ward for more complex or extended care. Once an admitted patient has been treated, they are then discharged. The flow of patients from ED bed to inpatient bed to home is foundational to a hospital's operations. However, if a patient has deteriorated such that they are no longer fit to go home after their admission, they are designated as "alternate level of care." More often than not, this means they no longer require hospital-level care but remain in hospital to wait for a long-term care bed.

Accordingly, lack of capacity in long-term care facilities also plays a role in ED wait times. Patients may end up stuck in the emergency department waiting long periods for a long-term care bed and occupying hospital beds that could be used for others waiting for care. In 2023–24, nine out of ten admitted patients spent up to 48 hours in the ED, while nine out of ten discharged patients were there for up to 7.7 hours [8].

Many patients are so frustrated with ED delays and lack of access that they end up leaving the ED. A recent BC study showed that around 142,000 patients left EDs without being seen in 2024, an increase of 86% since 2018-19 [9]. This can lead to patients returning to the ED with an exacerbation of their symptoms, requiring longer stays and higher treatment costs.

Canada's Health System in a Global Context

Among high-income countries, only a few others like the United Kingdom (1 hr 52 min) and France (2 hr 30 min) have similar or longer ED wait times. Most others, like the United States (25-35 min), Sweden (~38 min), and Australia (~18 min), have shorter average ED wait times, indicating substantial room for improvement in Canada's emergency care system [10].

Canada spends 12.1 percent of its GDP on healthcare, placing it among the top spenders on healthcare in the OECD [11]. Despite this, it ranks only seventh out of ten high-income countries in the 2023 Commonwealth Fund Survey, which evaluates health systems based on access to care, care processes, administrative efficiency, equity, and health outcomes [12]. Action is needed to improve the efficiency of Canada's health care system, especially since long ED wait times are a major obstacle to receiving timely care when needed most.

Ask 1: Improving Healthcare Data Interoperability

Background

Healthcare data interoperability refers to the ability of digital health systems (e.g., electronic medical records (EMRs) and hospital information systems) to transfer and review patient data seamlessly across settings, regardless of software vendor, location, or jurisdiction. Having such an integrated network helps mitigate inefficiencies in healthcare systems by reducing redundant testing and delayed diagnoses, which in turn can help shorten ED wait times.

Currently in Canada, a patient's health information is often not readily accessible to their various healthcare providers due to a lack of data interoperability. Epic, Meditech, and IBM collectively account for the majority of Canada's electronic medical record (EMR) market—at 41.3%, 22.4%, and 9.5%, respectively [13]. However, each system operates on distinct technical architectures that hinder seamless transfer of patient data across platforms. Moreover, even if two clinics use the same EMR vendor, data interoperability is not guaranteed. For instance, clinical data elements, such as laboratory results and medications, are rarely standardized across sites due to local configuration choices and site-specific adaptations, resulting in significant variability in how data is structured and exchanged [14]. Thus, there remains interoperability issues both at the inter- and intra-vendor level. Healthcare providers often need to manually review patients records or request data to be converted and sent over according to their appropriate format, which can be time-consuming processes that delays patient care. The scale of these inefficiencies is significant: studies applying interoperability benefit models estimate that limited data sharing contributes to nearly $4 billion in avoidable system costs and capacity inefficiencies annually across Canada [14].

Significance

Poor healthcare data interoperability in EDs has both direct and indirect effects. Directly, when ED physicians cannot access patients' health records, it hampers their ability to provide timely and effective care. This can lead to repeated tests or imaging, delayed or incorrect diagnoses, and inefficient use of limited ED resources. Indirectly, delayed care from other healthcare providers may cause patients to seek help in the ED instead, leading to unnecessary visits & overcrowding. These inefficiencies are clearly taking a toll on healthcare providers: a 2024 survey found that of 1,145 physicians and residents surveyed, 73% of them cited poor digital system integration or multiple unconnected systems as major challenges [15]. Additionally, a 2024 report from the Canadian Medical Association found that over a third (35%) of physicians who use an EMR claim they spend 2 extra hours each workday searching for necessary patient information. From a patient's perspective, having different physicians that operate in "information silos" is frustrating. For example, Brenda Andreas, a patient advocate and senior living in a rural

community in Saskatchewan, describes the arduous process she takes to reconcile information between her two specialists: “I have to contact health records, sign a consent, pay a fee, wait up to 6 weeks and then I get copies of my information which I can share [17].” Brenda is just one of many Canadians sharing this frustration, reflected in the fact that more than 4 in 5 Canadians want their personal health information shared electronically among all their health care providers when decisions are being made about their health [18].

Inefficiencies in health information sharing causes delays in diagnosis, prolonged patient stays, and consumes limited ED resources due to repeated tests, misdiagnoses, and long wait times. Having an interconnected data network that transcends jurisdictions, vendors, and individualized network configurations can greatly improve the timeliness and quality of ED care.

Past/Current Efforts

Canada has started to make progress on health data interoperability. In the 2023 federal budget, the government committed $505 million over five years to the Canadian Institute for Health Information (CIHI), Canada Health Infoway, and other federal partners [19]. The funding was intended to support provinces and territories in strengthening digital health tools, developing new health data indicators, and improving the use of data to enhance safety and quality of care [19]. This investment represents an important step toward supporting health human resources by easing system inefficiencies.

The Pan-Canadian Interoperability Roadmap, endorsed in 2023, sets a national strategy for standardizing how healthcare data is structured and shared. A key part of this work involves the use of FHIR (Fast Healthcare Interoperability Resources) standards, which helps to ensure that information such as lab results or medication records can be accessed in a consistent way across platforms and jurisdictions [20]. CIHI and Infoway have also developed the Pan-Canadian Health Data Content Framework, which focuses on reducing duplication and delays caused by inconsistent data collection [21]. Together, these efforts allow providers to spend more time on patient care and less on navigating fragmented or incompatible information systems.

On the legislative side, the federal government had introduced but not passed Bill C-72, the Connected Care for Canadians Act, in June 2024 [22]. This bill proposed to mandate interoperability requirements, prevent technology vendors from blocking data access, and establish compliance measures such as audits, complaint processes, and financial penalties.

Taken together, these initiatives show that Canada has laid a foundation for progress, but gaps remain. While investments, national frameworks, and legislation have all moved the issue forward, the system still struggles with fragmented information that slows care and contributes to burnout. Interoperability is not only a matter of technology but also a strategy for strengthening

the health workforce by improving efficiency, reducing stress, and allowing providers to focus on delivering better care.

Advocacy

Bill C-72 is a government bill introduced by former Minister of Health, Mark Holland, on June 6, 2024 [24]. It requires health information (HI) technology licensed, sold, or supplied by HI technology vendors to be interoperable, meaning that the user is able to easily, completely and securely access and use all electronic HI and exchange it with other systems, except where restricted by federal, provincial or territorial law. It also prohibits data blocking (any practice or act that prevents, discourages or interferes with access to, use, or exchange of electronic HI) by a HI technology vendor [22]. In brief, this act enables Canadians to securely access their own health data and provides healthcare providers with a streamlined way to access patient data.

Since Parliament was prorogued (paused) from January 6, 2025 until March 24, 2025 all government bills that had not received royal assent prior to prorogation ceased to exist. In order for government bills to be passed in a new session, they must be reintroduced as new bills or reinstated in the House of Commons. Bills are first introduced and passed by Members of Parliament in the House of Commons and then by Senators in the Senate before achieving royal assent (signed into law by the governor general or their representative).

Critics of this bill may bring up the issue of technology availability as a challenge to healthcare data interoperability. Although it is true that patients and providers must first have access to the relevant technology for interoperability to be important, access to technology is not currently a major issue in Canadian healthcare. Over the past two decades, Canada has made great progress in modernizing health records and nearly all clinicians now use some form of EMR [17]. For instance, 93% of primary care physicians reported using EMRs in their practice in 2022, up from 73% in 2015 [25]. Another more recent survey by the Canadian Medical Association and Canada Health Infoway found that 95% of Canadian physicians now use EMR compared to only 39% in 2010 [15]. Despite the increased use and availability of EMRs, many physicians still report spending significant time searching for missing patient information because of interoperability barriers. Thus, the issue now is more of policy (healthcare data interoperability) than technology, and Bill C-72 provides an effective means of addressing this gap to improve the overall efficiency of the Canadian healthcare system.

Data privacy is another concern that may be raised with data interoperability. Many patients are unaware of how their data are used or how to protect themselves from misuse. For example, one study found that nearly 70% of Canadians were unaware of existing health privacy laws [26]. To prevent exploitation, it is in the government's best interest to prioritize the protection of citizens' health information. Clear data privacy standards can be incorporated into Bill C-72 to ensure that data sharing is limited to relevant personnel and handled appropriately. Stronger requirements for

patient consent, coupled with greater transparency regarding how their data is used, can ensure that data practices are more closely aligned with patients' best interests. Implementation of monetary penalties for non-compliance can also safeguard appropriate data handling.

We call on the Canadian Government to reintroduce and pass Bill C-72 (Connected Care for Canadians Act) into law to improve healthcare data interoperability in Canada and ultimately, shorten ED wait times by reducing or eliminating inefficiencies caused by inaccessible healthcare data.

Ask 2: Supporting Rural and Remote Emergency Departments

Background

ED wait times disproportionately affect individuals in remote and rural communities, where access to timely, consistent primary care is limited by geographic isolation, health provider shortages, and under-resourced facilities. While 18% of Canadians live in rural areas, only 8% of physicians practice in those regions, leaving rural and remote residents with a higher chance of experiencing disruptions in ongoing (e.g., primary) care due to clinic closures or workforce shortages [27,28]. As a result, even non-urgent health concerns are often handled through the ED, leading to overcrowding and extended wait times.

The rural physician shortage has reached crisis levels, creating a cascade of effects that severely impact ED function and patient outcomes. For instance, Canada faces a shortage of 22,823 family physicians, with only 1,300 new graduates annually [29]. This makes it virtually impossible to close the gap at current rates, especially in rural areas, creating systemic vulnerabilities in rural emergency care delivery. Staff shortages cause unprecedented strain on rural EDs, with rolling closures becoming increasingly common. EDs across Canada have reported hundreds of emergency physicians signing open letters describing their inability to provide safe and timely care in overcrowded and understaffed EDs [30].

Significance

Rural emergency physicians face unique challenges, including professional isolation, limited resources, and the need to manage a broader scope of practice compared to their urban counterparts [31]. This isolation contributes to physician burnout and early retirement, further exacerbating workforce shortages. The COVID-19 pandemic intensified these pressures, as rural physicians faced additional challenges including limited personal protective equipment access, reduced specialist backup, and more complex patient cases from delayed medical care during

lockdowns [30]. Ultimately, this has led to rural providers reporting increased stress and workload.

The cumulative effect of these challenges in rural communities has created a cycle of deterioration that is difficult to break. As physician shortages worsen, rural physicians are left with heavier workloads and higher stress, which leads to burnout and turnover. This, in turn, exacerbates the staffing crisis and makes it even harder to deliver stable, reliable care [30,31]. This is highlighted in the figure below, where interconnected pressures driving overflowing EDs have downstream effects including patient stress, provider burnout, increased costs, and adverse health outcomes [32,33].

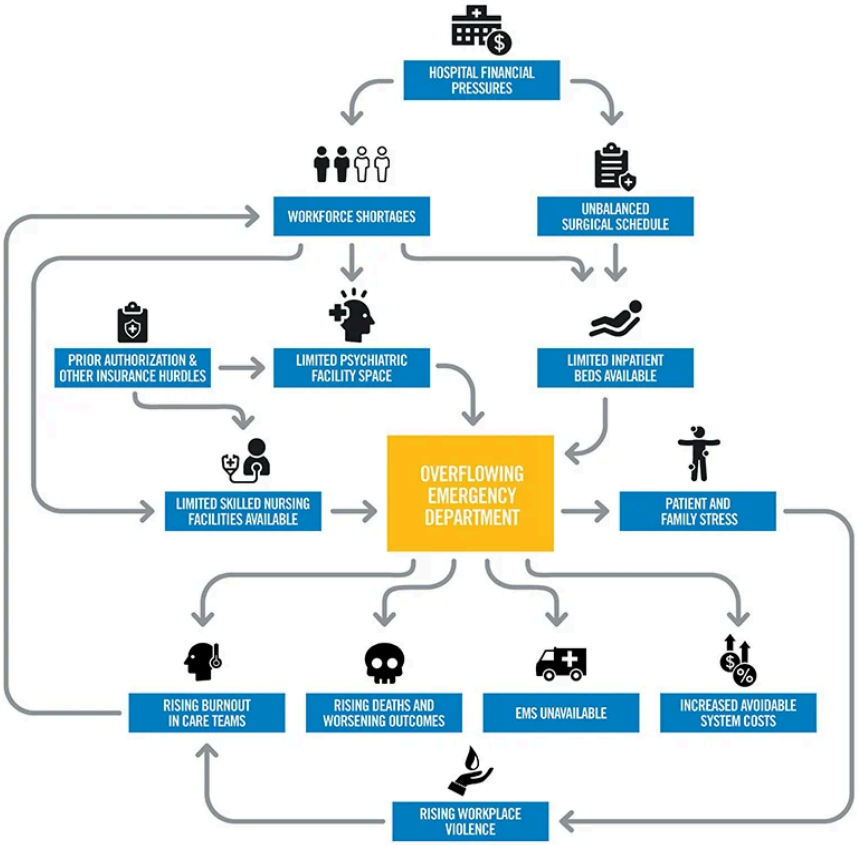

Figure 1: Systemic Determinants and Outcomes of ED Overcrowding (ACEP, 2025).

The shortage of rural emergency physicians leads to increased patient transfers to urban centers, creating a downstream burden on tertiary hospitals and compromising patient care. Without adequate rural emergency coverage, patients face longer transport times to urban centers, delayed care and increased risk of adverse outcomes, and our healthcare system accrues higher costs. It is clear that innovative approaches are urgently needed to preserve the sustainability of rural healthcare [29,34].

Past/Current Efforts

Strengthening real-time clinical support for rural ED providers is an evidence-based way to keep care close to home. Virtual peer-support models show promise in reducing unnecessary patient transfers, improving clinical decision-making, and decreasing overall ED congestion [35]. Programs such as Ontario's Emergency Department Peer-to-Peer Program and British Columbia's Real-Time Virtual Supports (RTVS) demonstrate how timely virtual consultation and peer support can improve patient care on-site, prevent rural ED closures and reduce the burden on tertiary hospitals [2,35,36]. However, interprovincial differences in healthcare delivery limit the feasibility of a fully national program ; therefore, these initiatives are best developed and administered at the provincial level [37].

Educational retention mechanisms, such as Canada Student Loan Forgiveness, aim to attract and retain physicians in underserved rural and remote communities [38]. Recent data reports the median debt for Canadian medical school graduates as $90,000, with 34% of students reporting debt of $120,000 or more [39]. However, students from rural and remote communities often accrue more debt, as demonstrated by the higher average, graduating debt of Northern Ontario School of Medicine students who largely come from rural and remote communities, at $190,000 [40]. Additionally, the Canada Student Loan forgiveness only applies to family doctors, family medicine residents, nurses, and nurse practitioners with a Canada Student Loan and payments are issued after each full year of service—reducing the program's recruitment impact [38]. Federal evaluations have also found that the financial incentive is often insufficient to influence relocation or long-term retention, underscoring its limited reach [38].

Lastly, advanced skill training for rural physicians is a proven strategy that can reduce wait times and improve access to care in rural and remote communities.. The National Advanced Skills and Training Program for Rural Practice launched in March 2023 and successfully trained hundreds of physicians in rural areas [41]. By building capacity directly within underserved communities, this initiative strengthens local EDs and ensures patients can receive timely, high-quality care closer to home. Despite its success, federal funding for the program ($7.4 million) ended in March 2024 because of its defined, short-term nature—a critical loss at a time when 94% of participants reported ongoing training needs [41]. The termination of this initiative represents a significant setback for rural capacity-building efforts, as it had demonstrated measurable impact in developing sustainable, community-based medical expertise.

Advocacy

International research confirms that professional development and training programs are among the most effective interventions for retaining physicians in rural and remote communities [42]. A systematic review found that educational strategies including "decentralized internships and

specialized training that combined strategies including management and education" were effective in improving health workforce retention in rural settings [42]. This suggests that comprehensive training and professional development opportunities not only enhance clinical competence but also help sustain the rural workforce over the long term.

The Society of Rural Physicians of Canada's (SRPC) National Advanced Skills and Training Program achieved remarkable results before funding ended in March 2024 [41]. This program trained 342 rural physicians across all provinces and territories, directly supporting 187 rural communities, including over 60 Indigenous communities and benefiting an estimated 1.3 million rural Canadians. Notably, 94% of participants reported ongoing training needs [41]. By enabling rural physicians to gain advanced competencies in emergency procedures, trauma management, and critical care, this “train-in-place” model strengthened local emergency departments and proved more cost-effective than traditional recruitment strategies, fostering long-term system sustainability and reducing the need for patient transport out of communities to receive these services.

Federal evaluation of the Canada Student Loan Forgiveness revealed significant limitations in current approaches that must be addressed [38]. Currently, the program only applies to family physicians, family medicine residents, nurses, and nurse practitioners in under-served rural and remote communities [43]. The existing forgiveness amounts for family doctors and family medicine residents ($60,000 over a maximum of 5 years) are also insufficient to offset the salary differentials typically required for rural practice, where annual premiums of $15,000–$20,000 may be necessary to compensate for professional isolation, extended on-call hours, and broader scopes of practice [38,44]. Thus, we call on the federal government to increase loan forgiveness amounts for rural/remote family physicians and family medicine residents—who usually take on the “rural generalist” role and provide both primary and emergency care—to a maximum of $100,000 over 5 years. This adjustment would consider the additional costs of rural practice and aim to increase rural physician recruitment.

We call on the Government of Canada to:

1. **Renew and expand funding for the *National Advanced Skills and Training Program for Rural Practice*, supporting a minimum of 500 rural physicians over 5 years, with annual public reporting on skills development and community outcomes.**
2. **Amend the Canada Student Loan Forgiveness Program to increase family doctor and family medicine resident forgiveness amounts to $100,000 over 5 years to strengthen rural physician recruitment.**

Ask 3: Strengthening Long Term Care

Background

Long-term care (LTC) in Canada provides 24/7, on-site delivery of supervised care including personal care (e.g., bathing, toileting), professional health services (e.g., nursing), and other services like meals, laundry, and housekeeping. It is designed for individuals who are unable to live independently in the community and for patients who, upon hospital discharge, are unable to return to independent living [45]. LTC homes are not covered by public health insurance and require residents to pay an accommodation fee, which varies based on province and accommodation type (e.g., private is more expensive than basic), although reduced rates are generally available for low-income residents [46].

Currently, more than 200,000 older adults and persons living with disabilities reside in LTC homes in Canada [47]. These facilities are facing a growing challenge of room availability, staffing, and an aging population. The Ontario Long Term Care Association (OLTCA) estimates that by 2029, Ontario alone will need over 30,000 new long-term care spaces and at least 58,600 more nurses and personal support workers to serve its aging population [48]. Across Canada, an estimated 454,000 LTC beds will be needed by 2035 to meet the projected demands of our aging population [49]. Further, studies report a 6.1% reduction in licensed practical nurses and a 2.1% reduction in registered nurses working in LTC homes between 2021 and 2023, with many providers planning to shift out of LTC homes [50].

Additionally, many individuals whose needs are better met by LTC homes are taken care of in hospitals as “Alternate Level of Care (ALC)” patients, meaning they require a bed for care, but not to the extent that a hospital provides. These patients in turn consume valuable hospital resources and occupy beds that otherwise could be used for acute care, contributing to delayed ED wait times. For every 100 ALC patients who leave the hospital and live in LTC, the health care system saves over $100,000 per day [51].

Significance

At first glance, the link between emergency department (ED) wait times and LTC may not be apparent. However, there are two significant connections between these topics that have potential to improve ED wait times. First, a high proportion of LTC patients visit the ED for preventable reasons, such as chronic illness flare-ups, medication mismanagement and infections. One study found that nearly one-quarter of LTC residents in Ontario visited the ED for potentially preventable reasons, most commonly pneumonia, urinary tract infection, and congestive heart failure. Only 11% of these visits were low acuity, meaning that ED visits from LTC residents are

quite costly to the healthcare system [52]. Another Canadian Institute of Health Information study reported that one-third of ED visits from LTC homes were avoidable [53]. Preventable ED visits consume hospital resources and contribute to longer ED wait times; thus, high-quality and safe LTC homes present a unique way of improving ED wait times by reducing ED visits from LTC and consequently, freeing up beds and resources. Second, as aforementioned, patients who are unable to return to independent living upon hospital discharge may be transferred to a LTC home [54]. However, if LTC beds are unavailable, these patients end up waiting in the hospital and occupying beds there, which results in further delays in the provision of acute ED care. These patients, usually of older ages (75+ years), are deemed "Alternate Level of Care," or delayed discharge, and contribute significantly to ED overcrowding and potentially delayed treatment for new patients in both urban and rural settings [55]; in 2015-2016, ALC patients used an average of 14% of hospital beds across Canada [49].

Finally, Canada is grappling with an aging population. By 2037, it is estimated that Canada's elderly population (65+ years old) will increase by 68% from 2017 [56]. In particular, the 75+ age group is expected to more than double during this time, stressing the importance of high-quality and accessible LTC homes, which are composed mainly of seniors (82% are 75 or older and 54.7% are 85 or older) [57]. Without further action to address the current shortcomings in Canadian LTC (e.g., safety and quality), growing patient demands will only worsen downstream effects on hospital resources and contribute to longer ED wait times.

Past/Current Efforts

Since the onset of the COVID-19 pandemic, the federal government has taken significant steps to strengthen long-term care (LTC) across the country, working in collaboration with provinces and territories. In the 2020 Fall Economic Statement, the government established the Safe Long-Term Care Fund, which provided a $1 billion transfer to support measures aimed at protecting residents and staff in LTC facilities. In addition, through the Safe Restart Agreement, $740 million was allocated to provinces and territories to enhance infection prevention and control measures, supporting not only LTC but also home care and palliative care services to protect vulnerable populations [47].

The federal government has also invested in programs designed to accelerate the adoption of best LTC practices. Since 2020, $10.7 million has been provided to Healthcare Excellence Canada, enabling over 1,500 LTC and retirement homes nationwide to implement innovative approaches to preventing and managing COVID-19 infections. One example is the LTC+ program, launched at Humber River Health's LTC homes in 2020. By using virtual physician care to reduce unnecessary ED visits, the program achieved a 35% reduction in such visits, effectively creating the equivalent of 7.32 additional acute care beds [58].

Building on these initiatives, the federal government has committed to longer-term structural support for LTC improvements. On February 7, 2023, the government reaffirmed its pledge of $3 billion over five years to help provinces and territories improve care standards and outcomes in LTC, a commitment first announced in Budget 2021. Furthermore, Budget 2023 introduced an investment of $1.7 billion over five years to support hourly wage increases for personal support workers and related professions, with the goal of strengthening recruitment and retention in the sector [47].

Advocacy

In 2023, the federal government of Canada released a discussion paper highlighting the need for a federal, Safe Long-Term Care Act [47]. In 2022-2023, the Standards Council of Canada, Canadian Standards Association (CSA) Group, and Health Standards Organization (HSO) released two complementary, independent national standards for LTC that provide guidance for delivering safe and reliable LTC services [59,60]. These standards (*Long-term care home operations and infection prevention and control* by the CSA Group and *Long-Term Care Services* by HSO) include guidelines on LTC building designs, quality control metrics, staff training, infection control policies, and operational procedures [59]. However, because provinces and territories are primarily responsible for LTC delivery and funding, these standards have yet to be mandated. Thus, at the federal level, an Act (federal law) that reflects these national standards and incentivizes provincial and territorial adoption is a definitive step towards safer and higher quality LTC.

Although LTC delivery (e.g., new facilities) is primarily a provincial/territorial responsibility, the federal government may strengthen the proposed Safe Long-Term Care Act by setting national benchmarks for LTC capacity: for example, a minimum number of LTC beds per 1000 people aged 65 and older. Such measures would help reduce the number of alternate level of care (ALC) patients in hospitals, improving emergency department workflow and system efficiency.

Finally, the Act should be grounded in the principles such as continuum of care, meaningful quality of life, inclusion, safety, transparency, and accountability. These principles, informed by extensive consultation with provinces and territories, Indigenous communities, stakeholder organizations, and LTC residents and staff, provide a clear foundation for a national vision of safe, and equitable long-term care in Canada [61].

We call on the Canadian Government to introduce a Long-Term Care Act that supports provinces and territories in adopting and implementing national standards for long-term care to reduce the number of ED visits from LTC homes and improve ED workflow.

Conclusion

Addressing emergency department (ED) wait times at the federal level in Canada is essential to ensure equitable access to timely, quality healthcare for all Canadians, regardless of their province or territory. Prolonged wait times compromise patient outcomes, increase strain on healthcare workers, and signal broader systemic issues in healthcare delivery and capacity. A federal response would provide the necessary coordination, funding, and policy leadership to support provincial efforts, promote national standards, and drive meaningful reforms. By prioritizing this issue, the federal government can help safeguard the core values of Canada's publicly funded healthcare system and ensure it remains responsive, efficient, and accessible to those in urgent need.

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