

## At A Glance

June 2007

### Monthly highlights of ICES findings for stakeholders

#### Ontario's Wait Time Strategy shows no evidence of impact on other surgical procedure rates

Paterson M, Hux J, Tu J, Laupacis A. *The Ontario Wait Time Strategy: no evidence of an adverse impact on other surgeries*. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2007.

<b>Issue</b>	The Ontario Wait Time Strategy (WTS), announced in November 2004, is focused on improving access to five key services – cancer, cataract and cardiac surgeries; hip and knee replacements; and, CT/MRI scans. Since its introduction, there have been anecdotal reports of decreased numbers of, and increased waits for, procedures that were not part of the WTS.
<b>Study</b>	Analyzed physician service claims between January 1992 and June 2006 for 27 surgical procedures that were not part of the WTS. Forecasted and actual quarterly rates for each procedure were compared after the WTS was announced to assess the impact of this strategy.
<b>Key Findings</b>	None of the 27 non-priority surgeries saw significant rate decreases after the introduction of the WTS, when compared with pre-policy trends. In fact, the rate of a small number of non-WTS orthopedic procedures appears to have increased since the start of the WTS.
<b>Implications</b>	Although there was no adverse impact on quarterly rates of surgery on a provincial basis, it is possible that rates may have decreased in some regions. Future studies should assess the impact of the WTS on surgical waits, particularly for urgent procedures where evidence suggests that delay may compromise outcomes. As well, since this study focused on a short-time period after the introduction of the WTS, ongoing monitoring is needed.

#### Emergency department use in the US and Ontario is very similar

Li G, Lau J, McCarthy M, Schull M, Vermeulen M, Kelen G. Emergency department utilization in the United States and Ontario, Canada. *Acad Emerg Med*. 2007 Apr 30; [Epub ahead of print].

<b>Issue</b>	Lack of health insurance is perceived to be a contributing factor to ED overcrowding in the US, but this has not been compared with areas that have universal health insurance coverage such as Canada.
<b>Study</b>	Examined 40,253 ED visits from the 2003 National Hospital Ambulatory Medical Care Survey in the US, and all ED visits recorded in 2003 by the National Ambulatory Care Reporting System in Ontario.
<b>Key Findings</b>	Annual ED visit rates were virtually identical in the US and Ontario (39.9 and 39.7 visits per 100 population, respectively). In both jurisdictions, those aged 75 years and older had the highest ED visit rate, and women had a slightly higher ED visit rate than men. The most common diagnosis was injury/poisoning, which accounted for 25.6% of ED visits in the US and 24.7% in Canada. Overall, 13.9% of ED patients in the US were admitted to hospital, compared to 10.5% in Ontario.
<b>Implications</b>	Differences in health insurance coverage do not appear to have a substantial impact on the overall utilization of emergency care. Increasing investments in ED infrastructure and personnel are recommended to reduce overcrowding.

#### Recent immigrants to Ontario have fewer pregnancy complications

Ray J, Vermeulen M, Schull M, Singh G, Shah R, Redelmeier D. Results of the Recent Immigrant Pregnancy and Perinatal Long-term Evaluation Study (RIPPLES). *CMAJ*. 2007; 176 (10): 1419-1426.

<b>Issue</b>	While people who immigrate to Western nations are believed to experience lower rates of chronic conditions than native-born individuals, data on pregnancy outcomes have not been compared.
<b>Study</b>	Tracked 796,105 women who were either native-born Ontario residents or landed immigrants to Ontario and who had a first documented obstetrical delivery between 1995 and 2005. Among these women, the development of maternal placental syndrome (MPS) was evaluated.
<b>Key Findings</b>	Overall, MPS occurred in 5.7% of women. The risk of MPS was lowest among those who had immigrated less than three months before delivery (3.8%) and highest in women living in Ontario for at least five years (6.0%).
<b>Implications</b>	To preserve the healthier state of new immigrant women, policies to discourage the adoption of adverse lifestyle choices should be designed. Since obesity is a risk factor for MPS, the goal for both long-term immigrants and native-born residents should be prevention of obesity and optimization of nutrition prior to pregnancy, but especially in childhood, adolescence and early adulthood.

## Decreasing salt intake could reduce the number of Canadians with high blood pressure

Joffres M, Campbell N, Manns B, Tu K. Estimate of the benefits of a population-based reduction in dietary sodium additives on hypertension and its related health care costs in Canada. *Can J Cardiol.* 2007; 23 (6): 437-443.

<b>Issue</b>	Hypertension is the leading risk factor for mortality worldwide. One-quarter of the adult Canadian population has high blood pressure, and more than 90% of the population is estimated to develop high blood pressure if they live an average lifespan. Recommended reductions in dietary sodium additives (DSAs) can significantly lower blood pressure. Health care cost savings associated with a Canada-wide reduction in DSAs have not been assessed.
<b>Study</b>	Reducing DSAs by 1840 mg/day would result in decreases in systolic and diastolic blood pressures by 5.1 and 2.7 mmHG, respectively. Canada Heart Health Survey Data were used to estimate the resulting reduction in hypertension. Costs of physician visits, laboratory tests, and medications were calculated from available health care data.
<b>Key Findings</b>	Reducing DSAs may result in 30%, or one million, fewer Canadians with high blood pressure, and almost double the treatment and control rate. Direct cost savings associated with fewer physician visits, fewer laboratory tests, and less medication use are estimated to be approximately \$430 million per year. Physician visits and laboratory costs would decrease by 6.5% and 23% fewer patients treated for high blood pressure would require medication.
<b>Implications</b>	Governments should consider that a significant reduction in the amount of sodium added to food by food industries would lead to a large reduction in hypertension prevalence and result in significant health care cost savings in Canada.

## Socioeconomic status is linked to higher ambulatory care-sensitive hospitalizations in children

Agha M, Glazier R, Guttman A. Relationship between social inequalities and ambulatory care-sensitive hospitalizations persists for up to 9 years among children born in a major Canadian urban center. *Ambul Pediatr.* 2007; 7 (3): 258-262.

<b>Issue</b>	Ambulatory care-sensitive (ACS) conditions are those for which timely ambulatory care may prevent the need for hospital admission. As such, ACS conditions are commonly-used indicators of access to primary care. However, few pediatric studies have examined socioeconomic disparities in ACS and non-ACS admissions in a universal health insurance setting.
<b>Study</b>	Examined ACS conditions and all hospitalizations of children born between 1993 and 2001 in Toronto by birth year, calendar year and socioeconomic status (SES).
<b>Key Findings</b>	Among 255,284 children born in Toronto between 1993 and 2001, ACS conditions were responsible for 28% of hospitalizations during the first two years of life and close to half of all hospital admissions during the third year. Low income was associated with 50% higher rates of ACS hospitalizations, including asthma and bacterial pneumonia, the leading causes of admission. Socioeconomic disparities in ACS hospitalizations and all admissions occurred in calendar year and age group. This effect was large, consistent across many conditions, remained stable over time, and persisted up to nine years of age.
<b>Implications</b>	As these findings occurred in a universal health insurance setting, the effect of SES on hospitalizations in children involves factors other than financial access to care. Given the magnitude of this effect and the substantial hospital costs involved, further studies are warranted.

### For more information contact:

Paula McColgan, Vice-President, Strategy and External Relations, ICES  
(416) 480-6190 or [paula.mccolgan@ices.on.ca](mailto:paula.mccolgan@ices.on.ca)