

- 2024-25: Canada saw 16.1 million ER visits total; 1.8 million required hospital admission; patients arrive sicker with multiple chronic conditions like diabetes, heart failure.
- Half of patients waited  $\leq 4$  hours total; 40% 5-14 hours; 1 in 10 (1.5 million)  $> 14$  hours in ER; 180,000 waited 48+ hours for inpatient bed, risking deterioration.
- Delays cause  $\sim 2,195$  extra deaths (1 death per 82 patients waiting  $> 6-8$  hours for bed transfer), per studies cited by Ottawa ER Dr. Michael Herman.
- High-acuity cases rose to 66% (life-threatening or urgent); not driven by minor complaints, contradicting "zombie myth."
- Older adults (55+) face longest bed waits due to need for specialized units/isolation; leads to hallway boarding in chaotic ERs.
- Upstream issues: aging population with complex chronic diseases; poor access to family doctors/specialists; waits up to 200+ days for MRIs/tests push patients to ER.
- Downstream: insufficient long-term care/home care; half needing LTC placement waited up to 44 days in hospital, blocking beds.
- Canada has among lowest hospital beds per capita and highest occupancy in OECD, limiting surge capacity.
- 7.7% of visits (1.2 million) left without doctor assessment (up from 5.4% pre-pandemic).

### Mitigating examples:

- Singapore: Individuals contribute to Medisave accounts (compulsory health savings from wages); government subsidies for low-income; hospitals compete on price/quality; patients choose fast public/private options with co-pays encouraging efficiency, resulting in short waits.
- Germany: Mandatory insurance via sickness funds; wide network of hospitals/GPs; higher bed supply; coordinated care teams manage discharges to home/LTC promptly; primary care gatekeeping (GPs control specialist referrals to prevent unnecessary visits) diverts cases, keeping ER flow smooth.
- Australia: Federal funding tied to performance targets (e.g., timely ED treatment, reduced wait times); GPs act as gatekeepers with incentives (extra payments for coordinated chronic care, keeping patients out of hospital); activity-based hospital payments (hospitals paid per treated case, incentivizing faster throughput); expanded outpatient/home care (subsidized community services) prevents unnecessary admissions and boarding without bankrupting via efficiency and prevention focus.
- Netherlands: Patients register with GP first for most care; GPs coordinate referrals; integrated provider networks ensure quick specialist access; robust LTC/home support (insurance-covered, means-tested) enables rapid hospital discharges, minimizing ER overcrowding.