POLICY BRIEF
Died on a Waiting List

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Executive Summary

Provincial governments often disclose their findings publicly when health inspectors discover even the most minor infractions during inspections of private businesses – mould on a soup can in a refrigerator, a missing paper towel holder, cold water at a handwashing sink, etc.

Despite setting a high bar for private providers, provincial governments do not hold themselves to the same standard when it comes to catastrophic failures that they oversee in the public health care system. Each year in Canada, thousands of patients die or suffer on waitlists without any disclosure from the governments that oversee them.

Too often, Canadians only hear of patients dying on waitlists for lifesaving treatment when patients or their family members speak out. Examples include: 18-year-old Laura Hillier's tragic cry for help in Ontario in 2016, Judy Anderson speaking out about her daughter's needless waitlist death in Ontario in 2021 and Debbie Fewster's family demanding answers in Manitoba in 2025 to name a few examples. [1, 2, 3] Stories like these are why, since 2020, SecondStreet.org has been dedicated to gathering, analyzing and releasing government data on patients dying while waiting for treatment.

This report examines government data on surgeries, procedures, diagnostic scans and appointments with specialists that were cancelled during the fiscal year April 1, 2025 through March 31, 2026 as the patients died. Highlights from this research include:

- 29,468 cases were identified where surgeries, procedures, diagnostic scans and appointments with specialists were cancelled as the patient died. This figure is underreported, as many health bodies do not track or disclose complete data.
- Since April 2018, more than 129,892 patients have died on waiting lists. Wait times range from less than a week to some spanning multiple years.
- Comparing data among health bodies that provided numbers for this past fiscal year as well as the year prior shows a 1.4% increase in waitlist deaths.
- These figures represent a wide array of cases including not only treatments that were potentially lifesaving, but also include situations where patients suffered while awaiting quality-of-life procedures. The latter involves patients requiring orthopaedic surgery, cataract surgery, and other procedures to address ailments in their final years.
- This research is backed up by recent polling that shows 18% of Canadians indicated they know someone who died due to a long wait time in the health care system.[4]

To reduce avoidable deaths and suffering of patients, provincial governments have a number of options to consider. They could, for example, replicate proven policies used in countries with better-performing universal health care systems: shifting

to fund hospitals based on output (activity-based funding), more partnerships with non-government providers to deliver services, allowing private options outside of the public system and introducing health care guarantees to improve accountability.

At the very least, governments could hold themselves to the same standards they hold the private sector by tracking, analyzing and reporting annually on the number of patients who died waiting for lifesaving treatment as well as the number who suffered harm while waiting for non-lifesaving procedures.

Introduction

On September 9, 2024, Alberta Health Services (AHS) inspectors walked into a daycare in the city of Airdrie (just north of Calgary) and discovered a sink area was missing a paper towel holder. Government officials later posted details about this relatively minor shortcoming on the department's health and safety inspections website.[5]

Alberta is not unique with this practice. It is common for governments in Canada to inspect restaurants, daycares, swimming pools and other private facilities for health and safety violations and then report the results publicly. Similarly, provincial workers compensation boards will investigate workplace accidents, sometimes naming businesses where violations occurred. Even minor incidents are reported. For instance, WorkSafeBC noted in September of 2019 that a young worker in the Lower Mainland was "using stilts while applying drywall mud tripped and fell to the ground." This accident resulted in "bruising."[6]

Bruising and a missing paper towel holder are, of course, trivial problems compared with the fact that patients sometimes die while waiting for treatment in the health care system. Even worse is that they die without disclosure as provincial governments do not regularly track, analyze and disclose data on this tragic reality. The double standard is stark.

In fact, when Manitoba patient Debbie Fewster died waiting for heart surgery in 2024, not only was the tragedy not disclosed by the government, but a freedom of information (FOI) response also showed that no health care staff suffered any consequences for contributing to Debbie's death by mistakenly classifying her priority case as a non-priority, contributing to her death.[7] Conversely, everyday Manitobans face penalties for far lesser mistakes, such as a $143 fine if they forget to update the address on their driver's licence after moving.

Sadly, media over the years have reported on many other patients dying while waiting for treatment. In 2016, 18-year-old Laura Hillier's call for help made international headlines as the teen described her long wait for lifesaving cancer treatment in Ontario. Similarly, 16-year-old Finlay van der Werken died while waiting for treatment in an Ontario hospital in 2024.[8] His story gained attention not because the government disclosed the failure but because his family spoke out. Judy Anderson, a retired Ontario nurse, shared with SecondStreet.org in 2021 that she had lost not one, but two daughters due to long wait times in the health care system. Meanwhile, Jerry Dunham of Alberta died in 2020 waiting for a pacemaker.[9] These are just a few examples.

Ideally, governments would report publicly each year on how many patients died the previous year due to long wait times. Such reports should also note how many patients suffered permanent harm due to delays in treatment. This kind of analysis would allow officials to identify problem areas and to enact changes to prevent avoidable deaths in the future.

As such reports do not exist, stories like Hillier's, and others, led SecondStreet.org in 2020 to start gathering government data on situations where patients died waiting for treatment the previous year.

Public opinion research reinforces the position that Canada has a serious problem in this regard. An October 2026 poll by Leger, commissioned by SecondStreet.org, found 18% of Canadians personally know a "Canadian who [has] died because of a long health care waitlist."[10]

Methodology and Considerations

In April 2026, SecondStreet.org filed FOI requests across Canada with over 30 government health departments, health authorities and health regions. The requests sought data for cases where patients were removed from surgical, procedure, diagnostic and specialist appointment waiting lists during the 2025-26 fiscal year (April 1, 2025 to March 31, 2026) as a result of the patient dying. This mirrors the approach SecondStreet.org has taken since the first *Died on a Waiting List* report in 2020. An example of the language used in FOIs related to diagnostic scans/specialist appointments is as follows:

> Please provide data on the number of patients that died while on a waiting list for either a diagnostic scan or a consultation with a specialist in fiscal year 2025-26. Please break the data out by scan/consultation and case info – date the patient went on the waiting list, date for the meeting with a specialist or date for diagnostic scan (if scheduled), and date of cancellation. Please also note the government's target time for providing the consultation or scan in question. (Note: many hospitals/ health regions were able to identify such cases as they track the reason for cancelled operations).

While this process helps shine a light on what is happening, the data gathered is incomplete.

For example, Saskatchewan's Ministry of Health only provided figures for surgical waitlist deaths, not diagnostic scans. Most provinces indicated they did not have figures on situations where patients died while waiting to meet with a specialist. Further, when SecondStreet.org began this research in 2019, AHS indicated its data was likely incomplete, as staff were never trained to track this metric meticulously. Similarly, Vancouver Coastal Health's 2026 FOI response noted their figure is "dependent on clerical staff receiving accurate information from the patient's family during the booking process."

In Ontario, a former senior health official indicated that the data, to his knowledge, was not tracked intentionally but is collected by chance due to the waiting list system software having "patient died" as an option that staff can click when cancelling a procedure.

This assertion is supported by the fact that SecondStreet.org often has to pay health bodies thousands of dollars each year to gather the data and release it. If governments had gathered the data regularly for internal analysis, there would be no charge to SecondStreet.org for compiling the information.

Further, readers should note this report does not cover situations where a patient did receive surgery but died during the procedure or shortly after due to conditions worsened by a long waiting period.

Overall, the data SecondStreet.org obtained from health bodies can generally be classified into two groups.

The first group includes cases where a patient may have died because of a long waiting period for treatment. For example, a patient dies from a heart attack after waiting too long for heart surgery or a diagnostic scan to identify a potentially fatal illness. The Nova Scotia Health Authority previously provided the most insightful data in the country for this category. For instance, their response for waiting list deaths during the fiscal year 2022-23 noted there were 532 total waiting list deaths, but only 50 were cases where patients were waiting for procedures that could have potentially saved their lives. The Nova Scotia government noted:

> Fifty deaths on the waiting list involved procedures where delays in treatment might reasonably be implicated causally. Among these are bowel resections; cancer resections and coronary artery bypass surgery. Among these, 19 patients were waiting beyond the recommended wait times for the procedure in question.[11]

This analysis is important, as it helps the public, and policymakers, understand how many patients may have died because the government simply took too long to provide treatment. Additional analysis could have examined those 19 cases to determine if any of those patients died for other reasons or if the government bore responsibility. Ideally, all

government health bodies should be able to note definitively how many patients died each year due to long waiting periods. Doing so would allow governments to identify problem areas and to take action to prevent future deaths. Such analysis and disclosure would increase accountability. Unfortunately, Nova Scotia no longer provides such detailed analysis.

The second group included in the data involves patients dying while waiting for surgery or diagnostic scans that would appear to be non-life-saving services (e.g., a hip replacement, a cataract operation, an MRI to examine shoulder pain, etc.). Such cases should not be overlooked, however, as long waiting periods may have affected patients' quality of life before their passing. Indeed, people often value their eyesight and mobility as much as life itself.

The story of late British Columbia patient Erma Krahn helps illustrate how lengthy waiting periods can affect a patient's quality of life. At 75 years of age, Krahn developed knee pain and spent five months waiting to see a specialist.[12] The specialist informed her that she required surgery but that she would have to wait "years" to receive it. Considering she was also battling lung cancer and did not want her quality of life to diminish during the time she had left, Krahn visited a private clinic in B.C. and paid for the surgery (note: at the time, the government made it much easier for B.C. patients to pay for this surgery locally).

While it seems unlikely that a patient would die due to not receiving something like a hip or knee operation in a timely manner, readers should consider that patients often have to live sedentary lives while waiting for such procedures. Inactivity can lead to other unrelated health problems – such as a heart attack – that do lead to a patient's premature death. Similarly, a patient with a poor hip could die after falling off a ladder, and a patient with poor vision (while they wait for cataract surgery) could have some kind of tragic accident due to their failing eyesight.

It is also entirely possible that in both cases – that is, patients waiting for potentially life-saving treatment and those waiting for non-life-saving treatment – death occurred for reasons unrelated to the health care system or the patient's medical condition. For example, the system may have scheduled surgery in a timely manner, but, during the wait, the patient died in a motor vehicle accident. Similarly, the patient's date for treatment may have been delayed due to poor health on the patient's part (poor health due to reasons unrelated to the treatment).

All of the ambiguity surrounding waiting list deaths and suffering could of course be cleared up if governments took more care tracking, analyzing and reporting on these problems in the health care system.

One remedy would be for governments to hold themselves to the same standards they expect private businesses to meet. As noted, the British Columbia government's WorkSafeBC program requires incident reports from employers whenever accidents occur. Even the most minor of incidents are reported publicly.

In Manitoba, the government discloses names of restaurants and businesses that break public health rules. For instance, in 2019, the province noted the Wood Fired Pizza restaurant in Brandon was shut down for "extensively remodel[ing] a food handling establishment without first registering."[13] Conversely, there is no consolidated data released on patients dying in the health system. The province does release "critical incident reports" regularly, but these are unhelpful for analyzing waiting least deaths. For example, in the October-December period of 2024, the government noted a patient died because "opportunities for community collaboration during pre-hospital care were not realized."[14] Such language is vague and lacks details on what caused the problem, efforts to fix the issue and how the system was held accountable. These reports are also not mandatory and are only triggered if patients, their family members or staff decide to request such a review.

Research Findings

Government data shows that in fiscal year 2025-26 (April 1, 2025 to March 31, 2026) there were at least 29,468 patients who died while waiting for surgery, a procedure, a diagnostic

scan or an appointment with a specialist (Table 1). Again, this figure is underreported, as some health bodies did not track or provide data.

No government body provided analysis to indicate the proportion of these cases that were situations where delays in treatment contributed to their passing (e.g. not providing heart surgery in time).

This year's total is the highest recorded by SecondStreet.org for a single year. However, this total also includes data from more health bodies than in previous years. For that reason, it is important to compare data provided by health bodies that also provided data the year before. Doing so shows a 1.4% increase in waitlist deaths.

Year-over-year analysis among health bodies that provided data for the past two years shows a 17.5% increase in surgical waitlist deaths but a 2.8% decrease in diagnostic scan waitlist deaths.

Difficulties occasionally arose while analyzing the data provided. For instance, Nova Scotia Health noted that "<5" patients died while waiting for 41 types of surgeries. Interior Health in British Columbia noted that 87 patients died while waiting for "other surgical procedures." Manitoba's Shared Health provided no target dates for waitlist deaths, making it difficult to know how many patients may have died after waiting longer than the maximum wait times.

Quebec, Canada's second most populous province, reported 11,548 cases where surgeries, procedures, diagnostic scans and specialist appointments were cancelled during 2025-26 as the patient died. It's important to note seven health regions in the province provided data on specialist appointments that were cancelled as the patient died. The only other jurisdiction to do so was Nova Scotia. Thus, the widespread inclusion of this data for Quebec undoubtedly elevated it to the highest waitlist death total in Canada. Wherever possible, SecondStreet.org did not count cases where patients died waiting for follow-up appointments with specialists. Quebec's health region for the East Island of Montreal (CIUSSS de l'Est-de-l'Île-de-Montréal) saw 410 cases where patients died while waiting for specialist appointments in oncology, haematology and gynaecology clinics. It's not clear how many may have been follow-up appointments. In addition, the health region reported 28 cancer surgeries that were cancelled as the patient had died. In Santé Québec Laurentides, there were 55 cases where a patient died waiting to see a heart specialist that were not follow-ups.

Ontario – Canada's most populous province – saw fewer surgical and diagnostic waiting list deaths in 2025-26 compared with the previous year (down 2.4%). However, these figures do not include cardiac waitlist deaths as those numbers are kept separate from Ontario Health and were not provided prior to finalizing this report. In terms of cancer-related cases, the government's data showed 115 waitlist deaths.

In western Canada, British Columbia saw a slight dip in annual waitlist deaths, dropping from 4,620 the previous year to 4,365 in 2025-26. While many responses included vague "other" categories, Vancouver Coastal reported nine cardiology waitlist deaths and 22 cancer-related surgeries and procedures.

Manitoba's number of patients that died while waiting for surgery nearly doubled, rising from 163 cases to 316 cases. Two patients died after waiting nearly two years for surgery; one was waiting for ankle surgery while the other was waiting for a cystoscopy. Four patients died while waiting for cardiac surgeries or procedures.

Alberta provided data for the first time in three years, reporting 878 surgical waitlist deaths. No data was provided for diagnostic scans or appointments with specialists. The government reported 52 cardiac waitlist deaths with a median wait time (upon death) of 23 days. No maximum recommended wait times were included for those cases.

In Saskatchewan, government data showed a slight dip in surgical waitlist deaths: dropping from 333 to 317. One patient had been waiting for more than two years for a total hip replacement when they passed away, while another patient had waited nearly two years for spinal surgery. The government's response noted that 36% of the surgical waitlist deaths were for patients waiting for cataract surgery. This is important context, but it is also important to note that 39% of those

TABLE 1

Patient Deaths While Waiting for Surgeries, Procedures, Diagnostic Scans and Specialists (2025-26)

Province	Surgical / Procedures	Diagnostic / Specialist	Total
British Columbia	**900**	**3,465**	**4,365**
Interior Health	206	1,403	
Fraser Health	217	1,516	
Northern Health	43	13	
Island Health	245	268	
Vancouver Coastal Health	189	265	
Alberta	**878**	–	**878**
Health Shared Services	878	–	
Saskatchewan	**317**	**111**	**428**
Ministry of Health	317	–	
Saskatchewan Cancer Agency	–	111	
Manitoba	**396**	–	**396**
Prairie Mountain Health	80	–	
Shared Health	316	–	
Ontario	**1,291**	**9,085**	**10,376**
Ontario Health	1,291	9,085	
Quebec	**1,879**	**9,669**	**11,548**
CISSS Bass-Saint-Laurent*	119	1,877	
CISSS Centre-Sud-de-l'Ile-de-Montréal	39	298	
CISSS Chaudiere-Applaches	–	459	
CISSS Outaouais	78	–	
CISSS Abitibi-Temiscamingue	37	88	
Santé Québec Laurentides**	967	1,510	
CISSS l'Est-de-l'Ile-de-Montréal***	187	422	
CISSS Monteregie-Centre	68	–	
CISSS Monteregie-East	108	–	
CIUSSS Estrie-Centre Sherbrooke	162	1,267	
CHU de Quebec Université Laval	114	3,748	
		–	
New Brunswick	**91**	–	**91**
New Brunswick Health	91	–	
Nova Scotia	**176**	**1,029**	1,205
Nova Scotia Health Authority	176	1,029	
Prince Edward Island	**3**	**178**	**181**
Health PEI	3	178	
Newfoundland & Labrador			
NL Health Services	Refused	Refused	–
TOTAL	**5,931**	**23,537**	**29,468**

* Follow-up specialist appointments removed from total.
** Excludes patients waiting to meet with a nutritionist, social worker, chaplain or physiotherapist. Also excludes follow-up appointments.
*** Total diagnostic, specialist appointments (not including follow-up), non-follow-up specialist appointments, respiratory tests and heart tests.

cataract cases were situations where the patient was removed from the waitlist after waiting longer than the target wait time.

Conversely, when it came to cancer-related cancellations due to the patient having passed away, Saskatchewan saw 111 cases, up from 86 the year prior. The government noted the following in their response, "each person is only counted once, even if they were referred to more than one specialty. People who were already active patients were not included." It also noted "patients may be already in a palliative condition when the cancer is first diagnosed and the referral is submitted."

Data from Atlantic Canada was incomplete. Newfoundland and Labrador (NL Health Services) refused to provide data, claiming it would have to manually create records. NL Health Services did however provide data the year before. In New Brunswick, the government provided surgical waitlist death figures but did not provide diagnostic scan data. It is not clear when each patient died, but at least 10 passed away after waiting at least a year after their "decision for surgery" date. One of these ten had been waiting at least two years before dying.

Nova Scotia provided data for both categories: patients dying while waiting for surgery or a procedure and patients dying while waiting for a diagnostic scan or an appointment with a specialist. The surgical/procedure data showed at least 176 patients died while waiting for treatment. However, this includes 41 cases where "<5" patients died while waiting for various categories of services. These were counted as one each but could increase the total by as much as 123 if each of those cases were four each. The number of patients dying while waiting for diagnostic scan/specialist appointments more than doubled over the previous year. The Atlantic Canadian province also saw 244 patients die while waiting for cancer-related care and 40 patients died while waiting for cardiology-related care. It is not clear how many died after waiting longer than recommended for those services.

One final observation for readers to consider is that while it may be tempting to compare data among provinces, this would often result in an apples-to-oranges comparison. This is because the breadth of data provided often differs by province. Recall, Newfoundland and Labrador did not provide data. Nova Scotia released some data related to cancelled specialist appointments while Ontario and many other provinces did not. Partial data was provided by health bodies in Quebec whereas a more complete picture was calculated for British Columbia.

Overall, if governments took the same interest in examining waitlist deaths that they do with reporting on missing paper towel holders in private establishments, all interested observers would know more about the problem and be able to make interprovincial comparisons.

Note: Readers interested in reviewing the data from each government body in this report are encouraged to visit www.secondstreet.org, as all responses are posted publicly.

Funding is Not the Problem

The Canadian Institute for Health Information estimates that provincial governments spent at least $269 billion on health care in Canada in 2025-26.[15] This works out to approximately $6,867 on a per capita basis, up dramatically from $1,670 in 1995-96. Had per capita spending kept pace with inflation, governments would only have spent $3,147 per person in 2025-26.[16] Thus, spending has increased at roughly triple the rate of inflation.

For much of the past 30 years, Canada has been one of the top spenders on health care in the world. Canada ranked third highest on spending as a share of GDP (adjusted for age) compared to other universal health care countries in 2024.[17] Despite this, it is well known that our system has fallen behind many other developed nations in terms of results. To be sure, some areas of the health system may require more funding to improve services for patients. Overall, however, it is clear that the system doesn't lack money. Health providers need to do a better job with the funds provided.

For example, while some have suggested administrative costs only represent a small portion of health spending, research shows otherwise. Despite claims that only one per cent of

costs in British Columbia are for administration, the true total is closer to 11%.[18] Many other reports and analysis show too often funds in the system are not used cost-effectively.

Policy Options

To address the large number of patients dying and suffering on waiting lists in Canada, governments should consider the following five policy options:

1) Better Tracking and Disclosure: Governments should, at the very least, track, analyze and disclose data on waiting list deaths each year. This could remove ambiguity around waiting list deaths while improving accountability. Such analysis could also help policymakers identify problem areas and work to improve shortcomings within the system.

A 2021 poll commissioned by SecondStreet.org found that 79% of Canadians think governments should carefully track and disclose data on how long patients wait for care, how that compares with maximum recommended waiting periods and what the eventual patient outcome is – including situations whereby patients die while waiting.[19] A 2022 poll commissioned by SecondStreet.org found 66% of Canadians believe governments should have to go further – by not only tracking waiting list deaths but also holding a press conference each year and announcing the number of patients that died due to long waiting lists. It would be remarkable if governments disclosed more information on patient suffering and thereby held themselves to the same standard to which they hold private companies.[20]

2) Activity-Based Funding: The Montreal Economic Institute, Fraser Institute and many others have, for years, recommended reforming the way hospitals are funded in order to incentivize higher output and better results for patients.[21, 22] "Activity-based funding" is a tool they have recommended as a possible solution.

This model sees hospitals funded based on services provided to patients instead of annual cheques to cover almost everything (global budgets). In practice, this would mean that a government might decide to pay, say, $20,000 for providing a knee operation. All providers would know they would receive that amount of money each time they provided such a service. This means that patients are no longer thought of as people "to have to help" but rather as customers that should be welcomed as they represent additional funding for the hospital.

Thus, this approach incentivizes output, as every patient that receives treatment results in more funding for the hospital. Not only does activity-based funding incentivize output and customer service, but it also helps hospitals focus on patient care rather than on some of the distractions that hospitals sometimes pursue. For example, the Windsor Regional Hospital has lost over $3 million through owning and operating two money-losing Tim Hortons franchises over the past decade.[23] Under an activity-based funding model, the hospital would have more of an incentive to focus on providing surgery for patients rather than continuing to subsidize double doubles.

A 2021 Fraser Institute report notes that "nearly all of the world's developed nations with universal-access health-care systems have moved away over the last three decades from global budgets towards at least partially having money follow patients for hospital care."[24]

Considering Canada would be a late adopter of activity-based funding, one benefit is that our country could learn from mistakes other nations made when they implemented this model decades ago.

3) Partner with the Private Sector: Governments in Canada and around the world have found that they can often deliver better care for patients by hiring private clinics (non-profit and for-profit) to provide treatment to patients in the public system. This relationship is similar to how a family doctor's office operates – a patient presents their health care card upon arrival, and the clinic then bills the government once the patient leaves. Thus, patients do not receive a bill for these services.

The Saskatchewan government credits their decision to hire private clinics with helping to reduce wait times and their

surgical backlog beginning in 2010. The Fraser Institute concluded that private clinics hired by the Saskatchewan government cost 26 per cent less per procedure – even though these clinics had to meet the same standards as government-run facilities.[25]

Data provided by the Saskatchewan government, however, indicated that hiring private clinics to provide care resulted in even larger savings: "… assessments showed that the difference between per procedure costs in public hospitals and private surgical centres are roughly 35 per cent in plastic surgery and general surgery day procedures, and up to 45 per cent in orthopedic day procedures."[26] Regardless of which study is correct, it was a positive outcome for patients.

Saskatchewan was not the only province to find cost savings through private partnerships. Ontario's auditor noted in 2014: "The Ministry estimated that certain services—such as MRIs, dialysis and colonoscopies—were about 20% to 40% less expensive if delivered in community clinics, including independent health facilities, rather than in hospitals."[27]

In Sweden, the government has gone one step further and hired a private company to manage one of their hospitals in Stockholm: Saint Göran Hospital. During a conversation with the hospital's CEO, Gustaf Storm, SecondStreet.org was told that the privately-run hospital provides the same level of care for "30 per cent" less than nearby government-run hospitals.[28]

Ultimately, providing the same quality of services for a lower cost allows governments to use the savings to provide even more care to patients.

However, how these arrangements are structured is important. In a 2025 policy brief, SecondStreet.org research director Bacchus Barua recommended a level playing field and transparent approach that is free of politics: an activity-based funding structure.[29]

By using this approach, Barua argues, not only would governments allot funding to providers based on output (and the complexity of the case) but the funds would also be allowed to flow to whichever facility a patient chooses for treatment: a government-run health facility, non-profit facility or for-profit facility.

If the government decided to pay, say, $20,000 for providing a knee operation, all providers would know they would receive that amount of money each time they provided such a service. This approach is transparent and puts patients first, as it wouldn't matter which type of facility a patient chose. In turn, this would see providers compete for patients and would have the incentive to spend health care dollars on expenses that help deliver care for patients (e.g. doctors and nurses) rather than expenses that do not (e.g. health care bureaucracy).

4) More Health Care Choices: A fourth policy option that governments could pursue – and one that would give more Canadians dignity during their final years – would be to increase the choices available to patients. Instead of forcing these patients to decide either to wait for the provincial government to provide a particular health procedure or to leave their province (or country) for care somewhere else, the government could keep the public health care system but allow non-government clinics in Canada to provide the same procedures.

This approach would be similar to how parents across Canada can choose to put their children in public schools or pay out-of-pocket and send their children to non-government schools. As the number of non-government health care clinics increases in Canada, they would not only increase patient choice but also take pressure off our public health care system.

Equally important, they would provide more patients with an alternative to pain and suffering. In some cases, access to private treatment in their own province would allow some patients to avoid dying while waiting for medically necessary care. Countries with higher-performing universal health care systems than Canada allow patients a choice between public and private health care services. This is something the Commonwealth Fund's international health care reports have routinely shown. In fact, an October 2026 poll commissioned by SecondStreet.org shows that a majority

(61%) of Canadians support allowing such a choice while only 25% oppose it.[30]

5) Copy the EU's Cross Border Directive: According to October 2024 public opinion research procured by SecondStreet.org, 73% of Canadians support copying a European Union (EU) policy called the "Cross Border Directive."[31] This policy gives EU patients the right to travel to other EU countries for health care, pay for the procedure, and then be reimbursed by their home government. Reimbursements cover up to the same amount their government would have spent to provide the surgery locally.

This policy could immediately help provincial governments in Canada reduce waiting list backlogs in Canada at the same cost per procedure to the public purse, as some patients would decide to travel outside the province for health care instead of depending on local health care. Not only would this benefit patients who decide to travel for health care, but it would also benefit those who remain in Canada. This is due to the fact that patients remaining in Canada for health care would move up a spot on the waiting list each time someone ahead of them chose to travel for health care.

Sweden, Denmark and other European countries have their own guarantees as well, ensuring patients either receive care in a timely manner or get to pursue private options within the country.

Conclusion

Government data obtained by SecondStreet.org shows at least 129,892 Canadians have now died on waiting lists since 2018-19. Again, this figure is greatly understated, as many health bodies do not provide complete data.

As noted in this report, it would be inappropriate to lay the blame for all of these waitlist deaths on the government's shoulders. They represent a variety of cases, and the stories behind the numbers are not known due to patient confidentiality. However, it is well documented that patient suffering is common in Canada.

Behind the figures in this report are stories of patients coping with chronic pain while they sit on the sidelines of life: parents who are unable to provide for their families while they're off work and waiting for surgery, seniors who are unable to see their newborn grandchildren's faces because of cloudy vision while they wait long periods for cataract surgery and other sad cases. Too many family dinners have empty seats as loved ones have passed away while waiting for lifesaving surgery.

Data shows that Canada spends a significant amount when it comes to health care. While there are many talented and hardworking staff working in the health care sector, the system itself needs to be much more efficient and accountable. A first step would be for all health regions to not only track the number of patients dying while waiting for health care services each year but also to examine how many of those patients died specifically because the government took too long to provide treatment. This would remove ambiguity over waiting list deaths and help officials identify problem areas and measure improvements once changes are made.

As this brief identifies, there are several other ways the system could reduce patients' suffering by copying what works well in Europe, including giving patients more choice outside of the public system, partnering with the private sector and funding output – not bureaucracies – to name a few. The system also needs greater accountability, with European countries offering several options in this regard.

In closing, unless reform measures are implemented, Canadians should expect to see this problem continue – and the deaths of patients rise – for years to come.

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