Nobel laureate John Polanyi has also entered the debate, accusing Canada of over-managing science. "Excellence is, as all acknowledge, a scarce resource," Polanyi says. "If one selects science on the basis of other criteria than that of scientific excellence, it can only be by compromising this indispensable criterion. The cost to the nation of doing that is not worth the nebulous gain. Yet we do it."

Ironically, the NCE's decision will likely weaken researchers' ties with industry.

CANVAC had negotiated arrangements with several pharmaceutical companies to conduct clinical trials in Canada, but those companies will now

go elsewhere, Klein predicted, as may some of the researchers. Canada has succeeded in attracting and retaining in this field. "You're going to be left with independent investigators doing their own investigating in their own labs," says Klein.

Sanofi pasteur says some of its agreements to test vaccine concepts developed by CANVAC researchers will be affected. Jim Tartaglia, the company's vice-president of research and development, says it's "too early" to know the complete impact of the funding cut, but the network may not be able to operate its new non-human primate facilities in Montréal and immunological monitoring in-

frastructure, in which Canada just invested \$15.7 million.

The decision also raises questions about a national laboratory to monitor and analyze the immune status of patients at various stages of a disease and their immune response to various vaccines. CANVAC was going to administer the laboratory.

Klein says he plans to return to Europe when his mandate as CANVAC's executive director expires. "The environment is not right [in Canada] to make vaccines. Clearly someone at the top does not understand what it requires to be competitive in vaccinology." — *Laura Eggertson, CMAJ*

WAIT TIME ALLIANCE

Benchmarks for "scheduled" cases unwise, experts say

Setting wait-time benchmarks for "scheduled" cases may mean those most in need don't get priority treatment, say experts about a recent report from the Wait Time Alliance.

The Health Canada-funded alliance, comprised of 6 medical specialty associations and the CMA, released its final report Aug. 10 (www.cma.ca). Based on focus groups, a national opinion survey and meetings with key people, the alliance recommends maximum permissible waiting times for certain radiological and imaging procedures, joint replacement, radiation therapy, cataract surgery, nuclear medicine and certain cardiac services.

Wait time maximums are defined for "emergency," "urgent" and "scheduled" care. The report acknowledges that delays most frequently occur with scheduled cases, which are defined as involving "minimal pain, dysfunction or disability."

But experts have been quick to question the wisdom of setting target waiting times for this broad category of patients.

David Hadorn, the former research director of the Western Canada Waiting List Pro-

ject commends the alliance for its "very useful" work, but says "We need a more sophisticated [urgency priority system] in light of the realities." He questions whether "scheduled cases" should even be on the list. "The gap between 'minimal' and 'unstable' is large and wide — and unaccounted for in this work."

This priority system "creates an unhealthy tension between treating according to need, and treating according to time on the list," says Dr. Gordon Guyatt, a professor at McMaster University in Hamilton.

Norway, Denmark and Sweden have all tried and abandoned benchmarks, he says.

Guyatt says Canada needs coordinated access to procedures with long wait times, such as the system for cardiac care in Ontario, which ensures the sickest patients get treated first.

The problem with setting wait-time benchmarks, say both Hadorn and Guyatt is the paucity of data concerning the effects of waiting. Without this data, wait times are arbitrary, says Hadorn.

The alliance report acknowledges this knowledge gap and

asks for an unspecified amount to increase research.

The alliance also wants \$1 billion for a national health human resources strategy aimed at self-sufficiency, and \$2 billion for a Canada Health Access Fund to reimburse patients for out-of-province or out-of-country care. This \$3 billion is in addition to the \$5.5 billion federal Wait Times Fund.

"Let's figure out how the [\$5.5 billion] should be spent" before adding more money, says Saskatoon health analyst Steven Lewis.

The alliance wants federal and provincial governments to establish wait-time benchmarks by the end of this year and to set reduction targets by Mar. 31, 2006, which is a year ahead of the governments' current schedule.

"The Supreme Court [Chaoulli] ruling has increased the speed of the treadmill," says CMA President Dr. Ruth Collins-Nakai. "If the provinces don't provide reasonable access to medically necessary services then it's appropriate for patients to buy third-party services." — *Barbara Sibbald, CMAJ*